

Rehabilitating the Wounded:

Historical Perspective on Army Policy



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e. Level V (CONUS Support Base)—This definitive level of care is provided in the CONUS support base. The patient is treated in hospitals staffed and equipped to provide the most definitive care available. Hospitals used to provide this care are not limited to US Army hospitals. Hospitals from the other military Services, the Department of Veterans Affairs (VA), and the civilian health care systems may also be included. Civilian hospitals include those hospitals that are members of the National Disaster Medical Systems (NDMS).

FM 4-02.10, Theater Hospitalization, 3 January 2005, Page 1 – 4

The AMAP vision for Army Medicine, VA and other support agencies is the creation of a sustainable health care system where all injured and ill Soldiers are medically treated, vocationally rehabilitated and returned successfully to active duty, or transitioned back into civilian life with follow-up health care provided by VA.

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Introduction

After an American soldier has been wounded to the point of needing long-term rehabilitative care and vocational training, there are three realistic courses of action available to the nation:

1. Treat casualties in military hospitals for as long as their rehabilitation and vocational training may take.
2. Treat them and train them in other government institutions.
3. Have them treated in the private (civilian) sector.

Each option has drawbacks:

1. Military hospitals have multiple missions, and providing long-term care can interfere with other military missions, including treating more patients and limiting other services; vocational training is only doubtfully a military mission.
2. Other government facilities (primarily the Veterans' Administration) have not always existed, have not always been able to provide adequate medical/vocational care, and potentially distance a patient from military discipline and control.
3. Civilian facilities are not under government accountability, potentially creating a problem for military discipline and control.

Yet each has strengths:

1. Military hospitals keep patients closest to the military, fostering esprit de corps, and providing accountability.
2. Veterans' Administration facilities have (since WWII) had a strong focus on rehabilitation medicine, and provide better continuity of care for patients who will not return to duty. Since WWI the VA has provided vocational training for veterans.
3. Civilian hospitals can be closer to a patient's home and can provide access to specialized care the government may not have. The civilian sector has substantial vocational training capabilities.

Using non-military hospitals also allows military hospitals to focus on other populations, including patients who will return to duty instead of those who will not, and provide extra hospital space should there be a surge of patients.

This study will look at how the nation has apportioned responsibility for rehabilitation. Since the military is first to treat wartime casualties, getting them from the battlefield to a hospital and then back to the U.S., in large measure the decision boils down to whether and at what point the Army hands patients off to another organization. At times the Army has tried to handle all patients itself, at times it has expected the VA to take patients

quickly, in the late Cold War various options were examined and planned but have not been implemented, current policy is something of a mix. Providing vocational training outside the military has never been as controversial a policy decision. It is not surprising that policy has changed over 80 years, but it has changed for various reasons. Several main reasons have been identified:

- The changing capabilities of medicine have allowed more to be done
- A changing political climate has required that more be done
- A growing GME program required complex patients
- The creation of CHAMPUS (later TRICARE) interacted with other factors
- The creation and capabilities of the VA

This study will cover the period 1917-2001. Until WWI, the state of medical care meant there was little chance of medical rehabilitation, and the nation provided disability pensions instead. Since 1917 there have been efforts to rehabilitate the wounded. 2001 is a convenient ending point, looking at the AMEDD's position on the eve of the first sustained combat operations since 1970, and is about as recent as can be called history rather than current events.

A further note is in order: this study uses period terminology, for instance asylum, Negro, and cripple. This is deliberate, in order to remind readers that times and attitudes have changed, and that the capabilities of medicine and surgery have changed in the 80 years under consideration. This study also does not look at clinical methods of treating patients, which has an extensive literature, nor at the history of disability and attitudes towards disability.

Executive Summary

1. **WWI.** The Army started significant rehabilitation in 1917, adopting a maximalist approach: the Army would do everything it could for the soldier. The goal was to “cure” soldiers, not for RTD but to return them to the labor force and avoid pensions to the disabled. The Army had to provide all aspects of care, from the battlefield to definitive medical care to rehabilitation, because there were no other government organizations able to provide those services. Vocational rehabilitation was the responsibility of the Federal Board of Vocational Education

The Army attempted to draw neat lines about what care was provided where. OCONUS hospitals would stabilize patients and handle all RTD wounded. CONUS hospitals would handle rehabilitation. However, “reconstruction aides” (civilian employees, now Occupational and Physical Therapists) provided care that speeded healing, and some were deployed overseas. Similarly, vocational rehabilitation did not suddenly start once a patient had been discharged, and the Army adjusted.

To provide care the Army built a substantial hospital system, including almost 40,000 General Hospital beds. Using civilian hospitals was considered, but rejected, except where a civilian facility was leased and operated as a military hospital.

Most patients were gone by late 1919, and in November 1919 the Army declared an arbitrary one-year period of care for most veterans. After one year, a patient would be discharged from an Army hospital essentially regardless of whether they had maximally recovered. Congress had authorized the Public Health Service (which then actually operated hospitals) to hospitalize veterans, which meant the federal government could meet its obligation to the veteran outside the Army. The Veteran’s Bureau (later Administration) would be created in 1921.

2. **Between WWI and WWII.** During this period, the Army had almost no rehabilitation capability. There was little need for it because there were negligible numbers of WIA. Most rehabilitation capability in Army hospitals was for Veterans’ Administration patients, who occupied roughly 20% of Army General Hospital beds. However, Army

policy (written into Army Regulations) was to provide all patients “maximum benefit of hospitalization” before discharge.

3. **WWII.** During the pre-war mobilization the inter-agency Federal Board of Hospitalization planned to use the large VA system to take non-RTD patients out of military hospitals. This would have created another echelon of care, with military hospitals handling complex RTD patients and the VA being used earlier to provide care to non-RTD patients. This policy apparently had only modest support in the AMEDD, and was being replaced in late 1942.

The major problem was poor quality of care in VA hospitals, which were understaffed and accustomed to semi-custodial psychiatric and TB patients. (At this time there were no drugs to treat such conditions and the standard of care was lengthy hospitalization.) The Army did not send WIA patients to the VA, but did send thousands of psychiatric and TB patients.

In late 1944 President Roosevelt said he wanted the Army to do as much as possible for WIA, and scandals broke around the VA in early 1945 for poor quality of care. Simultaneously, large numbers of WIA were returning from Europe, where they had been stabilized by several weeks or months in hospitals, plus the intense fighting on the German border was generating tens of thousands of WIA. The General Hospital system ballooned to over 160,000 beds, and other hospital categories were created to handle CONUS sick and injured as well as convalescents; these would hold roughly 80,000 more patients. (There was no use of civilian hospitals other than leasing facilities, many of them state mental hospitals.)

The Army had few rehabilitation assets, and since it was not willing to send patients to the VA there was a major buildup of patients in General Hospitals. The end of the fighting probably saved the AMEDD from having too many patients for available facilities. After the war the Army retained some discharge-eligible physicians (and enlisted prosthetics technicians) to handle definitive care of WIA.

4. **1946-1956.** Pres. Truman made improving quality of care in the VA a major priority, bringing in GEN Omar Bradley to clean house as Administrator. MG Paul Hawley, MC,

Ret. became Chief Medical Director and instituted a major Graduate Medical Education program to improve quality in the VA. At the same time the Army was extremely short of physicians, and there were various proposals to merge the military health systems or indeed all federal health systems.

With that background, in April 1950, Pres. Truman signed an Executive Order that sent “chronic” patients from the military to the VA. However, there were other factors for the Army. The Army’s nascent Graduate Medical Education program needed a range of patients and diseases to treat; over time, developments in medicine would change the definition of “chronic;” and Army dependents were not eligible for VA care. There were no answers forthcoming for these questions, but Army Regulation 40-680 established a six-month period, after which patients were presumptively “chronic” and should be administratively processed and transferred.

The Korean War caused significant problems for an AMEDD that had been cut back for budget reasons. Three General Hospitals were actually closed in the short time between the North Korean attack and the U.S. decision to send ground troops. In 1950 the military used available beds regardless of service – the Army sent patients to Navy and Air Force hospitals. VA patients and ‘chronics’ were sent from Army hospitals to the VA, clearing space. The Army hospital system was increased early in the war, and the VA was used, but civilian facilities were not. However, Surgeon General Raymond Bliss was vehemently opposed to sending patients to the VA and directed the AMEDD to deliberately avoid transfers to the VA. The Assistant Secretary of Defense (Health & Medical) learned of this and threatened Pres. Truman’s wrath; the problem was instead solved by the normal rotation of Surgeons General.

The Army had limited rehabilitation capabilities as the policy of transferring ‘chronics’ affected the size of the Medical Specialist Corps. Developments in medicine, however, meant that more patients would survive trauma and need substantial rehabilitation. The federal government chose to handle this in the VA, which by this time had established a substantial rehabilitation program.

In 1946 the Army instituted a program for partially-disabled personnel to stay on duty. By 1953 there were over 600, including over 50 officers who were tactical unit

commanders. The Army was willing to retain wounded personnel with good skills if the individual wanted to stay in the Army.

5. 1956-1973. With passage of the Dependents Medical Care Act (creating CHAMPUS) there were more ‘chronic’ patients who could not be transferred to the VA as they were not veterans. Moreover, the steadily-growing Army GME program needed those patients for teaching purposes. Simultaneously, rapid advances in medicine (e.g. therapeutic drugs for psychiatric patients) made it increasingly hard to define “maximum benefit of hospitalization” as medical care frequently included nursing care or out-patient care after in-patient hospitalization ended. In 1973 Pres. Nixon revoked the medical provisions of Truman’s Executive Order.

During the Vietnam War the Army made some use of other military hospitals, but generally avoided using the VA. Surgeon General Heaton was ambivalent about using the VA, apparently preferring to keep as many patients as possible in Army General Hospitals. However, when the Tet offensive caused a spike in patients, he unhesitatingly used the VA, and thereafter periodically urged General Hospital commanders to monitor length of hospitalization in order to control patient census.

Heaton obtained funds and personnel for only a modest increase in the General Hospital system. With that expansion of Army hospitals, and use of the VA, the Army avoided use of civilian hospitals.

6. 1973-2001. With the end of the draft, the AMEDD faced a shortage of personnel at the same time as the number of military beneficiaries increased, as soldiers were more likely to have families. The AMEDD used ‘physician extenders’ and also brought civilian healthcare into garrisons. As healthcare costs increased, the federal government sought to contain costs through resource-sharing between the VA and military systems; Surgeons General have usually praised these endeavors, at least in open forums.

As the all-volunteer military health system lacked capacity to handle the large numbers of casualties from facing the Warsaw Pact, Congress formally established a role for the VA, as there had been in 1940. This was not Echelon VI, but would include potential RTD patients. Concerns that the VA would not have enough capacity either led

to the Civilian-Military Contingency Hospital System, where civilian hospitals would also take patients, again a mix of RTD and non-RTD patients. The CMCHS was controversial until its purpose was broadened and it became the National Disaster Medical System.

While the AMEDD was willing to use civilian medical personnel for TDA care, willing to coordinate with the VA for cost-containment, and willing to use VA and civilian hospitals if there was a world war, actual WIA received sharply different treatment. (WIA is an inexact patient population, but few disease patients would need rehabilitative care, although some DNBI would.) Partly because of the high political profile of casualties and partly due to a changing military culture with 1)more junior personnel who wanted to stay in the Army and 2)more identification between senior officers and junior enlisted the Army was able to provide extensive care for the few WIA. Changes in medicine also meant that much more rehabilitation was possible, and that such care would take much longer.

There are various Memoranda of Agreement between the DOD and VA for transfer of special categories of patients, especially blinded, head trauma, and spinal-cord injuries. These patients all have lower RTD expectations than average, and are likely to have very lengthy recovery periods. As the VA had substantial rehabilitation capabilities for such patients, and the Army generally did not, these patients seem an exception to the general rule of the Army keeping patients for longer and longer periods.

Conclusions

Who and how much to rehabilitate are decisions that help shape and size the AMEDD, affecting what personnel and facilities are needed.

They should be considered within the overall mission of the AMEDD:

- Does the AMEDD exist mainly to care for RTD soldiers?
- Does the AMEDD care for any and all military personnel?
- What is the AMEDD's role for dependents and retirees?
- How does the AMEDD fit within the overall federal government?

In deciding the mission a real complication for the AMEDD is different eligibility for different populations. Active Duty, Reserves/National Guard, retirees, and dependents can all have different eligibilities for care at military treatment facilities and at the VA.

The AMEDD mission is also taking place against a background of GME, which is seen as necessary to recruit and retain medical personnel, and thus as a baseline requirement of the AMEDD.

The AMEDD sends mixed messages about rehabilitation.

- There are promises of maximal care for all, with "Wounded Warriors" receiving all care possible.
- There are budget constraints that have the organization looking for budget efficiencies.
- There are long-standing policies that send some categories of patient (for example spinal-cord injuries) to the VA sooner than other categories of patients.

As the AMEDD looks at the structure of its personnel and facilities after an unusual group of outside influences (the 2005 BRAC, the Grow The Army initiative, the DoD-wide shift to Essential Care In Theater with recovery to take place in CONUS) and the internal Army Medical Action Plan, the AMEDD needs to think about what its mission should be and make that case to various groups: the Department of the Army and Department of Defense, the Congress, the VA, the AMEDD's own personnel, and the American public. Wounded American soldiers are politically charged, and the decisions that are reached about care will have to be explained. Doing nothing for the wounded is not an option, doing everything for the wounded is not practical, so the question for contemplation and debate is how much should be done and by whom.

Chapter 1

World War I:

Initial Policy Decisions and Questions of Implementation

Introduction

During World War I, the Army debated and settled on a policy for how much care it would provide soldiers who would not return to duty. That policy was shaped by several factors, including the desire to avoid long-term expense to the government, to provide the disabled¹ soldier the best possible care, and the grievous shortage of non-Army facilities to provide long-term care for disabled soldiers. The federal government accepted that it had a duty to rehabilitate the disabled soldiers as much as was possible² (considering the capabilities of medicine, the severity of the medical problem, and the willingness of the individual to recover), and it assigned the overwhelming bulk of responsibility to the Army rather than other government entities. In fact, a special form of enlistment was provided for soldiers who had been previously discharged as disabled, so that they could be rehabilitated.³

This decision was a reflection of American society. While these Army policies were not created in a vacuum, this study centers on the Army rather than on pressures and views from the American public about cripples/disabled/handicapped. Those views changed as medical capabilities changed. In a nutshell, the American public expects their government to do as much as possible for their fighting men. Rather than spending much time charting changes in that view, the changing abilities of medicine serve instead as a shorthand.

The breadth and depth of the government's responsibilities would be debated, defined by policy decisions and laws, changed by further policy (and budget) decisions, and then discarded after the war. However, the Army took its responsibilities so seriously that it spent heavily on building the physical infrastructure, deliberately drafted para-

¹ For this study, "disabled" will refer to soldiers who will not return to duty. It does not differentiate between physical and mental problems, and it does not imply that the individuals have no future in civilian life, only that they are not able to return to useful military duty. Useful military duty is itself something that will change.

² The War Risk Insurance Act, as amended to 6 October 1917, insured the lives and the "physical ability of soldiers and sailors." History of the United States Army Medical Department in the World War (hereafter abbreviated MDWW) vol.13, p.247.

³ MDWW vol.13, p.5. No other information about this enlistment has been found beyond War Department General Order No.1, 2 January 1918, reprinted in MDWW vol.1 p.661.

medical personnel to perform rehabilitation, and hired female staff that had never had any connection with the military. It considered going wider still, into vocational education and government aftercare. The effort would advance the standard of rehabilitation medicine both inside and outside the military; after the Armistice the Army slashed its program, but never gave up its rehabilitation capabilities.

Ultimately, the Army would adopt a maximalist definition of rehabilitation:

Physical reconstruction is the completest form of medical and surgical treatment carried to the point where maximum functional restoration, mental and physical, may be secured. To secure this result, the use of work, mental and manual, will be required during the convalescent period. This therapeutic measure, in addition to aiding in greatly shortening the convalescent period, retains or arouses mental activities preventing hospitalization, and enables the patient to be returned to service or civil life with the full realization that he can work in his handicapped state, and with habits of industry much encouraged if not firmly formed.

Hereafter no member of the military service should be recommended for discharge from your hospital until he has attained complete recovery or as complete recovery as it is to be expected he will attain when the nature of his disability is considered.⁴

The government, however, was not entirely humanitarian in adopting this maximalist position. The Army sought, on behalf of the nation, to make the disabled “wage earners and independent of charity,” in an age when government expenditure was watched carefully.⁵ Rehabilitating men was good business, for it was expected to help avoid the expensive pensions that were provided to veterans after the Civil War.⁶ It would also head off a need for long-term hospitalization, further reducing government expenditure.

There were scant resources to achieve this ambitious goal. The Soldiers’ Home (established 1851) and the National Homes for Disabled Volunteer Soldiers (post-Civil War) were retirement homes for at most a few hundred men. St. Elizabeth’s Hospital was the federal “insane asylum;” it normally handled men who developed psychological problems in military service, but was again too small to handle the numbers of patients from an Army that expanded roughly 40-fold between 1916 and 1918. The Public Health Service operated a system of hospitals, but the system had grown out of its original role as the Marine Hospital Service. They were thus largely in ports, and also handled quarantine cases and immigrants. In any case, the existing responsibilities of the PHS

⁴ MDWW vol.13, p.8. This definition was adopted in April, 1918.

⁵ Memo to CSA, 7 Dec 1917, National Archives and Records Administration Record Group 165 roll 275 document 8574-30. Hereafter, archival sources will be identified with the Record Group (RG) and box or roll numbers.

⁶ Raising tax revenue off rehabilitated men was less likely; the threshold for income tax was around \$3000 and perhaps 1% of the population paid income tax.

hospitals did not disappear when war was declared, so the PHS had little extra capacity to handle more (and long-term) patients. The Federal Board of Vocational Education would be utilized during and after the war, but it had only been created in 1916 and its function was to administer federal matching funds to state vocational education programs. Finally, the Army had a total of 9,530 hospital beds available.⁷ However, while that number was adequate for a peacetime Army of approximately 120,000, it would be manifestly inadequate for the wartime Army that would expand to around 4 million.

Moreover, few of the 9,530 beds could play any useful role in rehabilitation: a large number of beds were scattered around at the multitude of small posts and were essentially infirmary beds rather than hospital beds, and there were only four General Hospitals and five Base Hospitals. Furthermore, some of those were of negligible use. For example, Army & Navy General Hospital at Hot Springs, AR was primarily used for rheumatic patients; the hospital at Ft. Bayard, NM was used solely for tuberculosis patients. The Army would have to find resources for its rehabilitation program amid the national mobilization for war.

Setting Policy

Establishing a policy for the Army took over a year. Part of the problem was the number and range of activities that the mobilizing Army faced. Part of the problem was establishing a uniform federal policy, which meant waiting on other departments and on Congress. Part of the problem was confusion within the Army Medical Department, as newly-uniformed physicians (typically enthusiasts for rehabilitation) urged over-broad goals for rehabilitation.⁸

The Army made an early start on organizing rehabilitation: on 15 August 1917 COL Theodore Lyster, MC, recommended the Surgeon General appoint someone to consider “reconstruction, reeducation, and aftercare of disabled soldiers.”⁹ A week later COL Frank Billings, MC, was appointed head of the Division of Special Hospitals and Physical Reconstruction with a remit so broad it might include helping veterans find

⁷ MDWW vol.5 p.25

⁸ For a short introduction to rehabilitation in general, see “50 Years of Vocational Rehabilitation in the USA 1920-1970,” Rehabilitation Services Administration, Department of Health, Education, and Welfare, 1970. (Hereafter 50 Years of Vocational Rehabilitation)

⁹ MDWW vol.13 p.3.

jobs.¹⁰ For several months the few officers studied the problems, consulting the Allies about their experiences and reading medical literature about rehabilitation.¹¹ On 7 November 1917 a lengthy and detailed plan was submitted by the Surgeon General to the Secretary of War.¹² It had a number of points that would be problematic:

- Patients would not be discharged until maximally cured, including “training of any kind” that would improve the patient’s “social worth.”
- A future vocation would be assigned to the patient by the Army vocational officer.
- There was no provision for psychological patients.
- Patients would have to be kept in the Army after the war was over while their comrades were being discharged.
- The military was to take civilian patients and rehabilitate them. (This may have applied only to those injured in war industries.)

Before the General Staff could fully digest this, elaborations on the plan were submitted.¹³

The bulk of the staff of the Division of Special Hospitals and Physical Reconstruction were vocational experts, and they were working on programs of instruction. These would no longer be picked by the doctor as appropriate for the patient; patients were to be consulted about what they wanted to do as well as considering what they could do. However:

- It would be extended to Navy personnel, explicitly to “the industrial Army” (workers in war industry), and “can be extended and made a permanent plan for the reconstruction and rehabilitation of all civilian disabled workers in the future.”
- A “Reconstruction Teaching Corps” would be established, and because of the “enormity” of “reconstruction and rehabilitation [as] a national problem” the Surgeon General sought help from other governmental and private agencies.¹⁴
- The government would help disabled soldiers buy farms after the war.
- Sixteen rehabilitation hospitals would be created, plus sixteen each of TB sanatoria, mental asylums, and blind/deaf hospitals. These would take patients from Level V hospitals. (There were sixteen draft districts, and the plan was to hospitalize patients closer to their homes.)

¹⁰ MDWW vol.13 p.4. Billings was a former president of the American Medical Association, appointed a colonel in the mobilization.

¹¹ Apparently the British were well advanced in rehabilitation for orthopedic patients, but the Americans wanted a broader program. A.F. Mastellone, “Physical Medicine in the Army: History and Development,” *Military Medicine* (Sept. 1959), pp.641-45.

¹² MDWW vol.13 pp.9-28, including forms and outlines of vocational instruction.

¹³ 4 December 1917, MDWW vol.13 pp.28-36.

¹⁴ RG165 roll 275 document 8574-30.

There were useful conclusions from the planning. First, the principle of maximal rehabilitation was clearly stated. Second, it clearly included what would later be termed physical therapy and occupational therapy. Third, planning numbers were provided: the AMEDD could expect 50-75,000 patients per year per million soldiers overseas (i.e. 5-7.5%), plus normal accidents and sickness in the U.S. Fourth, an unheralded planning assumption was that no patient returning from overseas was expected to return to duty; Level IV hospitals overseas would handle all RTD patients. Level V hospitals in the U.S. would only handle non-RTD evacuations, although they would of course receive RTD patients by transfer within the U.S. Fifth, rough percentages of patient types were provided (although omitting psychological cases) so that facilities could be established.

However, concurrent developments outside the Army brought a delay. Secretary of War Newton Baker sent the plans back for reconsideration because the Council of National Defense (a group that brought private-sector experience and contacts to helping the federal government address the unprecedented scope of mobilization) was also pondering rehabilitation and apparently drafting legislation, as were the Navy and the Public Health Service.¹⁵ In early January 1918, Baker brought the matter up at a Cabinet meeting. President Woodrow Wilson directed that a larger group meet and consider the whole issue of rehabilitation for the federal government; it included the Army, Navy, Public Health Service, Bureau of War Risk Insurance, Interior Department (which ran St. Elizabeth's), Federal Bureau of Vocational Education, Red Cross, Department of Labor, American Federation of Labor, U.S. Chamber of Commerce, U.S. Employees' Compensation Bureau, Treasury Department, National Manufacturers' Association, the medical profession, and the Red Cross Institute for Disabled and Crippled Men. There was also a Canadian delegate.¹⁶

This large group was turned into a committee and continued deliberations, apparently using the Army plans as a basis. By late January and February recommendations were forwarded to the General Staff and the Secretary of War, with mixed results. On 25

¹⁵ Memo, 15 Dec 1917, RG165 roll 275 document 8574-30, MDWW vol.13 p.36, RG165 roll 346 document 10785-9.

¹⁶ Canadian presence was indicative of seeking lessons from our co-belligerents. French and British medical opinion was sought, and Medical War Manual No.5 was titled Lessons from the Enemy: How Germany Cares For Her War Disabled. (Philadelphia: Lea & Febiger, 1918). The Red Cross Institute was itself a brand-new organization.

January the Secretary of War accepted the general policy but rejected plans for vast numbers of rehabilitation hospitals.¹⁷ Meanwhile, the Judge Advocate General rejected caring for non-military personnel.¹⁸ The JAG was pointing out that Congress had done nothing that would allow the government to care for such patients, and further doubting that Congress would embrace anything that sweeping. The enthusiasts who had drafted the plan let their medical/humanitarian interests get far ahead of anything that was a government responsibility, and they were also operating in a vacuum, for there were no patients returning from overseas.

Chastened, the committee quickly sliced out the over-reaching parts, and on 23 February 1918 the Surgeon General resubmitted the program.¹⁹ Policy was to rehabilitate all line-of-duty patients to their maximum extent, which would require around 5,000 more Medical Department personnel. (No comments have been found about treatment of non-line of duty patients, either in WWI or later. Apparently, non-LOD overlapped with the current category of Existing Prior To Service.) There were several reasons to get started sooner rather than later: patients were already trickling back from France and needed care; the AMEDD needed to start now if it was going to have hospitals ready when more wounded were received (60,000 were predicted by the winter 1918-19); and camp hospitals needed to pass on their long-term patients. There was also a sugar-coating: the Army could use its new capabilities to actively habilitate draftees for duty.²⁰ The Secretary of War promptly approved the policy although at first restricting it to enlisted men. Rehabilitation work had already started at Walter Reed General Hospital now it was expanded to fifteen more hospitals.²¹ Memos continued to fly around the Medical Department and General Staff, especially because Congress was considering legislation,²² but the Secretary of War was clear that the Army should get on with

¹⁷ RG165 roll 275 document 8574-87

¹⁸ MDWW vol.13 p.38.

¹⁹ RG165 roll 346 document 10785-3.

²⁰ From early 1918 the Army was concerned to use as many draftees as possible, and created the category of Limited Service. See "Below the Bar: The US Army, manpower standards, and sub-standard manpower in WWI," paper read at the 2007 Society for Military History conference by Dr. Sanders Marble.

²¹ RG165 roll 346 document 10785-4. The details of what was happening at Walter Reed are unclear.

²² Presumably what became the Vocational Rehabilitation Act of 27 June 1918, PL 178-65. This Act required the Federal Board for Vocational Education to handle vocational rehabilitation for military personnel. The FBVE had been established for very different reasons, but was the only federal government organization with any expertise in the field, so it was pressed into service.

medical rehabilitation without waiting for a government-wide policy. He drew a line between “proper medical treatment by the War Department” and “subsequent treatment” (e.g. vocational training) which was not an Army responsibility.²³

Mental Patients

All this discussion about rehabilitation focused solely on patients with physical problems, and there was no attention paid to mental patients. Although documentation is sparse, two reasons can be suggested. First, psychology was in its infancy, with limited numbers of practitioners and limited techniques of counseling and psychotherapy. Additionally, there were no therapeutic drugs for psychological disorders. The combination of these factors meant there was little expectation that mental patients could be rehabilitated. Second, there was an established route for the military to dispose of mental patients: St. Elizabeth’s Hospital. Before the war, mental patients (if not a danger to anyone) could be discharged on a Certificate of Disability for Discharge; those judged insane before enlistment (i.e. not LOD) were discharged to their home state or to their family, and those LOD and/or dangerous were sent to St. Elizabeth’s. In any case, each disposition had to be signed by the Secretary of War.²⁴

As the Army mobilized, recruits were accepted by the draft physical and sent to training camps, where they received another physical. Administratively, they had been in federal service from the time they passed the draft physical, so all those rejected at the second hurdle for mental reasons were now eligible for hospitalization at government expense. Since the Medical Department believed that strict screening for mental weakness would avoid “shell shock” patients, and draft boards were not necessarily rigorous in their examinations, around 70,000 men were weeded out by the Army physical examinations.²⁵ St. Elizabeth’s was soon swamped, as was the AMEDD bureaucracy. Authority was delegated from the desk of the Secretary of War all the way down to commanders of regiments and post hospitals. Army Regulations were amended on 13 December 1917 to send mental patients to any public mental hospital, which opened access to state as well as federal resources. On 20 November 1918 new guidelines

²³ RG165 roll 346 document 10785-13.

²⁴ MDWW vol.10, pp.139-143. These procedures applied to enlisted men; officers were referred to a retiring board.

²⁵ MDWW vol.10 p.164.

had obvious incurables discharged as soon as possible, but other (less-ill) patients held 120 days in Army hospitals to see if there was chance of any recovery.²⁶ Over in France, “shell shock” patients (as combat stress was then termed) were treated forward, with an expectation they would recover, and most did RTD. The Army only listed 3,647 shell-shock patients of the hundreds of thousands of men who saw action, which suggests the great majority were treated and returned to duty without being hospitalized.²⁷

To round out care of mental patients, by early 1919 the Army had a three-fold policy.²⁸ Curable cases were treated in Army hospitals. Those that proved incurable were transferred to St. Elizabeth’s or other public asylums closer to home so the family might “possibly contribute to his comfort and amusement;” if the family desired it (and could afford it) patients could be transferred to private asylums with the Bureau of War Risk Insurance paying part of the costs but the families responsible for the balance. The Army thus was hospitalizing mental patients, at most four months, and had specialized hospitals for the purpose. By late March 1919, the BWRI was building its own facility for long-term hospitalization and also readying contracts with asylums, and the Army modified its policy slightly.²⁹ Only “criminally insane” were sent to St. Elizabeth’s, while normal insane were held in Army mental wards until the BWRI had somewhere to send them; greater continuity of care would be better for the patients. A month later, with the BWRI ready to take mental patients, the Secretary of War approved a policy that patients had four months to improve before being discharged to a BWRI hospital, and thus the Army exited the business of caring for long-term psychiatric patients.³⁰

Blurry lines in amputee care

The Army intended to care for patients overseas, but cure and rehabilitate them in the U.S. This seemingly straightforward differentiation quickly broke down. Amputees received not only physical therapy in France (because it speeded healing of stumps) but

²⁶ MDWW vol.10 p.147. Otherwise there was negligible effort to rehabilitate mental patients. *Ibid.*, p.95.

²⁷ MDWW vol. 15 part 2, p.577. Others may have been Carded for Record Only, but the details of psychiatric care in WWI are beyond the scope of this study. See MDWW vol. 10, for more details. There is also a robust literature on shell shock and general military psychiatry.

A point worth considering in light of recent research about Traumatic Brain Injury is the possible physical causation of some “shell shock” cases. I am obliged to LTC Melissa W. Jones for this point, raised in her discussions with Leslie Davidson in March 2008.

²⁸ RG165 roll 307 document 11096-1.

²⁹ RG165 roll 307 documents 11096-2 and -3.

³⁰ RG165 roll 307 document 11096-4.

temporary prostheses because those could help both mental and physical healing.³¹ The Army arranged temporary prostheses for about one-fifth of leg amputees, a total of 500 temporary legs.³²

Back in the U.S., there was the question of who would provide final prostheses. There was a substantial artificial limb industry that had initially been fueled by Civil War amputations and then sustained by industrial accidents. The Army decided not to get into limb manufacturing, and not to specifically draft men from the brace/limb manufactories. However, there was a clear need for limbs, and the Army wanted to prevent the skilled craftsmen from taking other (possibly more lucrative) work but instead to continue manufacturing limbs.

In the opening months of the war the Army thought it might be in charge of all care for amputees, through to fitting final limbs, but on 6 October 1917 the Congress assigned final prostheses to the BWRI. Some Army doctors lamented the division of responsibility between the AMEDD and the Treasury, and they argued that it was not good for the patient's mental state or his physical recovery to wait until the very end of recovery for a prosthesis. Apparently unilaterally, the Army decided it could make and fit temporary prostheses, and thus the Army began buying and issuing wood-fiber limbs.³³ In what looks like another toe over the line, in January 1918 the Surgeon General established a limb laboratory at Walter Reed, mainly to test existing commercial models but also to make experimental limbs.³⁴

Problems differentiating rehabilitation and vocational education

There was another breakdown in the Army's attempt to have clear policy. Patients were only supposed to be cured, not rehabilitated in France, and rehabilitation in the U.S. was not supposed to involve vocational education. (government oversight of vocational training, job placement and "economic and social supervision, to see that rehabilitation is complete and so remains" was considered in early 1918 before the Vocational

³¹ MDWW vol.11, pt.1, p.688. Weight-bearing on leg prostheses helped stump recovery, a wartime discovery by the Belgians.

³² MDWW vol.11, pt.1, p.707. The other 80% presumably were evacuated to CONUS without a temporary prosthesis or died before returning to CONUS.

³³ MDWW vol.11, pt.1, p.717.

³⁴ MDWW vol.11, pt.1, p.716. Little information is available, but it presumably was abolished in the 1920s.

Rehabilitation Act.³⁵) However, when occupational therapists (then bundled with physical therapists under the term “reconstruction aides”) were assigned to hospitals in France because their work speeded recovery, the line blurred. (Occupational therapy in 1918 was substantially different than it is today. In part, it was almost a literal term: the therapy of having something to occupy time instead of being bored and bedridden with stress about future employment prospects. It might involve nothing more than reading material or handicrafts to fill time. In June 1918 reconstruction aides were sent to France, while more elaborate OT was, apparently, reserved for hospitals in the U.S.³⁶) Occupational Therapy also applied to teaching patients skills for new jobs, and recovering motor skills that would help them toward employment. That same policy also declared “the Medical Department ... must have full and undivided authority over the disabled soldier during the entire period required for his cure.”

Doctors noted that patients longed for “cheer-up” work, but wanted it to be “real” and that real work and/or education would be taking place under War Department control, blurring the line in the U.S. just as it had been blurred in France.³⁷ The Army accepted that “treatment of diseases and injuries embraces not only anatomical but functional restoration,” which meant accepting the female occupational and physical therapists onto the fringes of an all-male Army.³⁸ With different terminology being used by different parts of the War Department, a month later the Secretary of War ruled against the Medical Department. While “work, mental and manual” could be required during convalescence, the Army was still going to discharge soldiers once they had recovered as far as they could. Their vocational training was a government responsibility, but not an Army one.³⁹

³⁵ MDWW vol.13, p.37

³⁶ See Harriet Lee and Myra McDaniel, eds., Army Medical Specialist Corps (Washington, DC: GPO, 1986), pp.83-90. (Hereafter AMSC) and Ann Ritchie Hardwick, The Army Medical Specialist Corps: The 45th Anniversary (Washington, DC: Center of Military History, 1993). (hereafter Ritchie Hardwick, AMSC 45th Anniversary) For the overlapping physical therapy, see AMSC pp.49-52.

³⁷ RG165 roll 346 document 10785-17.

³⁸ MDWW vol.13 p.39. OT and PT were “too broad and too technical to be performed satisfactorily by enlisted personnel of the Medical Department.” MDWW vol.13 p.56. In WWI the Army Nurse Corps was recruited by the Red Cross and lacked rank. They were paid by the federal government and could receive medals and awards, but could not give legal orders.

³⁹ The Army also sought to keep marginally-fit men in service as “limited service,” freeing fitter men to fight. It was thus not interested in planting the seed of post-war employment and discharge in soldiers’ minds, and thus kept the FBVE out of Army hospitals. MDWW vol.13 p.254.

As with many government programs, there was a corresponding publicity campaign.⁴⁰ Since rehabilitation was relatively rare, the priority was explaining what was happening. Three target audiences were identified: the public had to be educated about the need for rehabilitation, soldiers' families had to be told that discharge would be delayed until after rehabilitation, and the last category was the patients. The Army fed the press censored articles to sway public opinion,.

Caring for the Patients

To handle the expected overseas casualties (predictions were 5% of the strength WIA, 2% DNBI), the AMEDD had to expand dramatically. From 9,350 beds (mostly small post hospitals that were little more than sickrooms) the Army spent \$242,865,512 to get 149 hospitals, 4,621 buildings, and 123,899 beds.⁴¹ Plans were underway for another 60,000 beds.⁴²

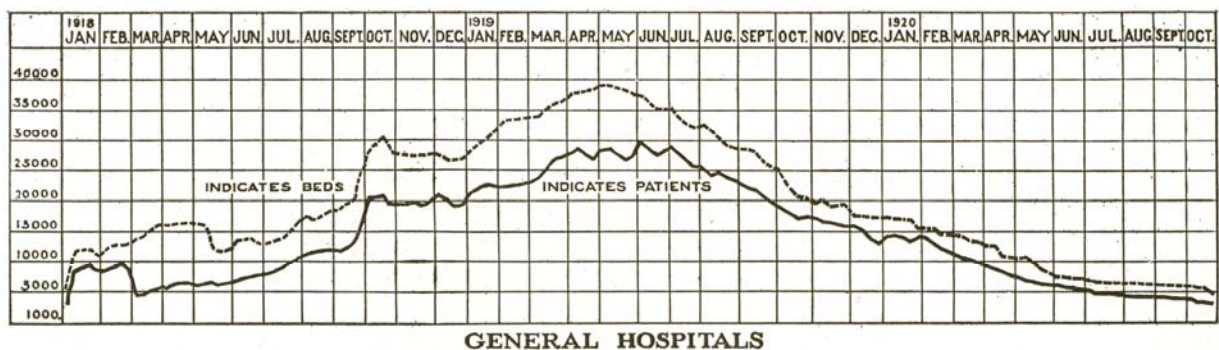


FIG. 11.

MDWW vol.5 p54.

The initial plans were that patients would be hospitalized six months, thus the 7% beds could be halved to 3.5%. This is an interesting point because maximal rehabilitation was expected to take only six months, thus affecting the size of the GH system. However, wartime plans more than doubled the size of the planned Expeditionary Force.⁴³ Initially the option of using beds in civilian hospitals was considered, but ran into three problems:

- the bed supply would be uncertain

⁴⁰ ARSG 1919, pp.1174-5.

⁴¹ MDWW vol.5, pp.54, 56.

⁴² MDWW vol.5, p.112.

⁴³ MDWW vol. 5, p.28.

- there would be hardship for local civilians if their entire hospital was taken by the military
- there would be administrative problems with both military and civilian patients in the same hospital

Thus to keep troops “absolutely under military control” the Army would operate its own hospitals.

Temporary buildings were thrown up, especially at mobilization camps, and civilians volunteered a large number (and variety) of properties for military hospitals. The AMEDD examined private homes, barns, sanatoria, and other buildings and then leased the ones judged suitable. Leasing was a cumbersome process (the paperwork had to be signed by the Secretary of War) that took 2-6 months from the AMEDD deciding it wanted a building to doors opening.⁴⁴

General Hospitals were the main facilities to be used for OCONUS patients; a few were built but most were leased. TB hospitals were generally located in ‘healthful’ locations (mountains or deserts) while other hospitals were mainly located in the east.⁴⁵ Expectations were for 60% of wounded and 80% of disease patients to be ambulatory; both of these would be underestimates. Most GH could cover a range of patients (they also received complicated patients from other hospitals in CONUS) but most were assigned specialty programs to improve treatment.⁴⁶

Planning estimates were 10,000 patients per month from overseas (plus those from within CONUS), and that would obviously lag behind major combat operations: the Level IV hospitals overseas would have to treat patients. There was indeed a lag, but because major combat operations for the AEF began so close to the end of the war, the evacuation of patients and the demobilization of the AEF were largely simultaneous. From December 1918 to June 1919 numbers were over 10,000 per month, and the AMEDD had to use hospitals at mobilization camps. Ultimately there would be 147,868 patients from overseas, and almost half of those were sent to GHs between 1 April 1918 and 30 June 1919 – in addition to the patients referred from other CONUS hospitals. The

⁴⁴ That 2-6 months was considered cumbersome is a reflection of how fast temporary buildings could be built. It is also a reminder of how little refitting had to be done for a hospital in 1918. MDWW vol. 5, pp.30-1.

⁴⁵ MDWW vol. 5, p.35.

⁴⁶ MDWW vol. 5, pp.173-5 has a list of GH with specialties.

busiest GH was at Fort McPherson GA, receiving 6,971 patients in that 15-month period, over 450 per month.⁴⁷ On Armistice Day the GH had 19,357 patients in 24,156 beds, with a further 14,629 beds under construction.⁴⁸

4% of beds were programmed for neuropsychiatric patients, but mental patients were far fewer than expected. The AEF only returned 4,100 mental patients, although another 450 “mental defectives” were sent back through medical channels.⁴⁹

Problems Implementing Rehabilitation

Until late 1918 there were few patients to handle: the AEF had few battle casualties and the Level IV hospitals in France and Britain were treating them. First, they had to see if the patient would return to duty, and second, even if RTD was clearly not going to happen, the patient needed to be stable before being shipped back to the U.S. Accidents and sickness in the U.S. did generate some patients, but the numbers were undoubtedly small in comparison with the numbers of battle casualties.

However, the unexpectedly quick end to the fighting meant the AEF could be rapidly reduced, and patients were shipped back to the U.S. faster than expected. Despite the mammoth expansion of Army hospitals, despite pressing other government resources into action (for instance using a Home for Disabled Volunteer Soldiers as a temporary Army hospital⁵⁰), there were not enough beds. The first problem was handling the number of rehabilitation cases, and in December 1918 two dozen hospitals were added to the rehabilitation program, more than doubling the number available.⁵¹ That, however, was not enough to solve the problem, and in mid-January 1919 convalescent centers had to be established to relieve the rehabilitation hospitals of minor cases.⁵² Ultimately nineteen centers were established (using old training camps, as units were demobilized from the camps) and they handled 47,858 soldiers between 25 January and 28 April. Out-processing over 500 soldiers per day (and having to treat them first) shows that they were indeed minor cases, but it also shows that soldiers were not looking to hang around in convalescent status.

⁴⁷ MDWW vol. 5, p.175.

⁴⁸ MDWW vol. 5, p.113.

⁴⁹ MDWW vol. 5, pp.37, 176-77.

⁵⁰ RG165 roll 205, document 8574-272.

⁵¹ MDWW vol.5, p.142. A fortieth hospital was added in 1 May 1919.

⁵² ARSG 1919 p.1178. See also MDWW vol.13 p.45.

Indeed, patients were trying to get out of hospitals faster than the Army wanted. If there had been a bolus of patients arriving over the winter, they were only staying a few months, and some rehabilitation experts were worried that patients were undermining their own recovery. The normally dry official history records:

At this time there was an anxiety to be discharged among both officer and enlisted patients that amounts almost to hysteria and was universal, leading to a great difficulty in retaining in the service sufficiently long to effect maximum restoration of function any man who was not confined to bed. Everyone seemed to have an almost uncontrollable desire to get out of the service and to go home and do nothing but rest for several months. Patients would make all manner of optimistic statements as to their conditions, obtain guarantees from relatives and friends for necessary treatment after discharge, and in many other ways influence medical officers, against their better judgment, to recommend discharges. To relieve the pressure brought to bear by relatives and friends of homesick disabled soldiers, and because these patients would not respond to the fullest extent to treatment in a military hospital while in this frame of mind, the War Department gave authority on December 31, 1918, to discharge such men, on their own application, who furnished documents from relatives or friends which guaranteed the necessary specialist treatment after discharge, and released the War Department from further responsibility for their treatment.⁵³

As this extract hints, a major official concern was future pension claims against the government for disabilities; the guarantee of future treatment was meant to heal the patient and remove any future liability on the taxpayer. One memo noted that discharging patients because they wished it would be “doing away with all reconstruction with a consequent mounting of our pension roll to an extent never dreamed of after the civil war.”⁵⁴ It also indicates that the soldiers were paying little attention to the publicity efforts that were trying to explain how wonderful rehabilitation was. One group of patients that clamored to be discharged had a particularly straightforward reason. Under the War Risk Insurance Act, the blind would receive \$100 per month, far more than enlisted pay, and would keep family allotments. The Army arranged for the Red Cross to take over the hospital for the blinded, and in two weeks the patients were all discharged and the responsibility of the BWRI and the FBVE.⁵⁵

The peak patient load was in March 1919, and patient numbers dropped in April and May, with the number of rehabilitation hospitals following.⁵⁶ May and June were spent handling patients and planning for reductions; the prediction was only 8,000 chronic patients beyond 31 July 1919, and on that basis the Division of Physical

⁵³ MDWW vol.13 p.49.

⁵⁴ RG165 roll 275 document 9452-251. See also document 9452-247.

⁵⁵ ARSG 1919 p.1175.

⁵⁶ ARSG 1919 pp.1176, 1178.

Rehabilitation and Special Hospitals was abolished on 20 June.⁵⁷ By 30 July the Army handed over fourteen hospitals with 13,222 beds to the Public Health Service; the PHS was temporarily charged with caring for long-term patients on behalf of the BWRI.⁵⁸

The interim nature of the PHS was a problem, and the Army had already run into legal problems. The War Risk Insurance Act promised medical care, but Army hospitals were not initially authorized to provide care. It was already a problem at the beginning of February 1919, and the Secretary of War wrote to the Secretary of the Treasury (responsible for the BWRI) suggesting the BWRI could reimburse the Army for care given.⁵⁹ It was a practical suggestion, and it was adopted.

On 7 November 1919, two years to the day after the initial detailed plan for maximal rehabilitation by the Army of all sorts of patients, the Army promulgated a further hospital-reducing policy. Now, all patients (except Regular Army officers, “special surgical cases,” and mental patients) would be discharged after one year in hospital. They were still a government responsibility, and the BWRI, Soldier’s Home, and National Homes for Disabled Volunteer Soldiers would care for them, but they were not an Army responsibility.⁶⁰

Discharging patients (and getting BWRI reimbursement for others) meant the Army could reduce its hospital system. With the end of the fighting, Congress lost its interest in funding a large military hospital system (there were more Army hospital beds on 11 November 1918 than there were soldiers on 5 April 1917); the FY 1920 budget cut funds for civilian employees by approximately 85%.⁶¹

⁵⁷ MDWW vol.13 p.50.

⁵⁸ MDWW vol.5, p.190.

⁵⁹ RG165 roll 205 document 8574-295. The costs were expected to be about \$1 per day.

⁶⁰ MDWW vol.13, p.51 According to *ibid.*, p.201, this mainly applied to tuberculosis patients. Special surgical cases apparently meant those still recuperating, and mental patients apparently still had the four-month observation period before discharge to a mental hospital. Surgeon General M.W. Ireland mildly modified this by allowing patients who “will fully recover within a reasonable length of time” to stay if they wished. MDWW vol.1 p.1082.

⁶¹ Circular Letter 146, SGO, 20 March 1919, in MDWW vol.1 p.848.

Chapter 2

1919-1940: Between Wars

Introduction

As the Army sorted through the aftermath of WWI, it soon confirmed the policy of maximal reconstruction. In 1922, Regulations laid down that once men had “reached the condition of maximum benefit” a Certificate of Disability for Discharge could be filed.⁶² This would be slightly modified in 1926, so that men whose enlistment expired while they were in hospital awaiting “maximum benefit” would still be discharged, and that stayed the rule until WWII.⁶³ These discharged soldiers fell under another provision of regulations,⁶⁴ and stayed in Army hospitals but were paid for by the Veterans’ Bureau (later the Veterans’ Administration).

In the interwar years the Army shrank to around 130,000 men, so the number of soldiers needing long-term rehabilitation was quite low. Some other government personnel were eligible for Army hospitalization, but likely the bulk of experience the Army had with long-term patients was with VB beneficiaries. Public expectations of rehabilitation seem to have been low, presumably in keeping with the capabilities of medicine.

The Veterans’ Bureau

On 9 August 1921 Congress created the Veterans’ Bureau, charging it

shall be responsible for the proper examination, medical care, treatment, hospitalization, dispensary, and convalescent care, necessary and reasonable after care, welfare of, nursing, vocational training, and other such services as may be necessary...⁶⁵

for WWI veterans. Some details reveal that Congress was not quite as generous as it seemed: conditions had to be in the line-of-duty (apparently to rule out conditions that existed prior to service), veterans had to apply for treatment within a year of the act passing, and deserters (and other undesirables) were not eligible at all. Over time eligibility would expand, largely as the American Legion became a powerful lobbying organization, and Spanish-American War veterans and peacetime retirees would be

⁶² AR 615-300, Enlisted Men: Discharge, 6 December 1922.

⁶³ AR 615-300, editions of 1 March 1926, 14 September 1927, and 4 April 1935.

⁶⁴ AR 40-590, Medical Department: The Administration of Hospitals, General Provision, 15 December 1924, allows them to stay as long as the hospital commander judges “proper and necessary.”

⁶⁵ Public Law 47-67.

eligible. A major change in 1924 was caring for non-LOD patients, who would now be termed non-service-connected, i.e. an accident or disease after leaving military service. The VB would have its own facilities, could hire space in other government facilities (federal state), and could also contract to civilian facilities for care.

Army hospitals had been taking BWRI patients since 1919, and would immediately start taking VB patients (indeed, patients would change status without leaving their beds), but the Army began trimming back its rehabilitation now that the VB existed to handle veterans. There was an intermediate step, as between mid-1919 and August 1921 the Public Health Service operated some 20 hospitals (with physical and occupational therapy) and the Army transferred supplies and civilian employees (which included Reconstruction Aides) to the PHS in 1919.⁶⁶ However, from 1921 the Army had only very limited responsibility for long-term care of patients – and the pre-war regulations about transferring mental patients to St. Elizabeth’s apparently were revived, so that the Army would not handle any long-term mental patients.

The Army general hospital system: developments

Through the 1920s and 1930s the AMEDD operated only six CONUS general hospitals, with limited bed capacity.⁶⁷ The hospitals were Walter Reed, Letterman, William Beaumont (completed 1921), Army & Navy, Fitzsimons, and the station hospital at Ft. Sam Houston (it functioned as a general hospital but was termed a station hospital). Aside from the \$1 million construction of William Beaumont in 1920-21, there was no substantial capital spending on Army hospitals until 1940, except that funded from the VB. In 1921, \$750,000 in VB funds were spent on Fitzsimons, and Army & Navy was rebuilt largely with VB funds in 1932-33.⁶⁸ The general hospitals had limited capacity; at

⁶⁶ MDWW vol.13 p.250.

⁶⁷ General hospitals were the closest analogue to a present-day MEDCEN, while station hospitals were roughly analogous to MEDDACs. General Hospitals were the only ones staffed or expected to perform advanced surgery and rehabilitation. (“Reconstruction” was only done at general hospitals. AMSC history, p.91.) There were three OCONUS general hospitals, Sternberg in Manila, Gorgas in the Panama Canal Zone, and Tripler in Hawaii. All were general hospitals only because of the difficulty in evacuating patients to CONUS and were really beefed-up station hospitals.

⁶⁸ ARSG 1921 p.103

the end of FY1921, there were only 4,514 beds⁶⁹ and by 1940 it was still only 5,077 beds.⁷⁰

Of that limited capacity, the VB/VA used a large amount. This made sense for the federal government: why have largely empty military hospitals and pay money for more veterans' hospitals? It could also make sense for the Army:

- veterans brought some money. Although the inter-government reimbursement rate was typically below the cost of a hospital bed, it was at least something.
- veterans brought a more diverse patient population than the younger, healthier Active Duty soldiers. It thus helped the Army's nascent GME program, which from 1925 put young doctors through an interne (as it was then termed) year.
- veterans paid for civilian AMEDD employees.⁷¹

The alternatives were a reduction in professional readiness or explaining to a tight-fisted Congress why Army hospitals were empty and Army doctors were only working limited hours. As a result, for many years in the 1920s, there were more VB patients in Army hospitals than Army patients, and Fitzimons (with TB patients) and Army & Navy (with hot springs for arthritis patients) could have over two-thirds VB/VA patients.⁷² (More soldiers were admitted, but they had shorter stays.) When the Army recorded PT/OT statistics, the VB patients seem to have also taken a disproportionate amount of therapy, thus potentially preserving some PT/OT capability in the Army system.⁷³ The drawdown in Army hospitals in 1919 led to the dismissal of many Reconstruction Aides, who went over to the VB.⁷⁴

The downside of taking veterans was dancing to someone else's tune. In the 1920s, Congress expanded veterans' benefits, and veterans flocked to Army hospitals.⁷⁵ When the VB cut back the number of civilian beds it contracted, the Army got more patients.⁷⁶ When, in 1933, the VA slashed eligibility, Army hospitals had an exodus of patients – but also had an exodus of civilian staff. 818 AMEDD civilians were cut from

⁶⁹ ARSG 1921 p.104

⁷⁰ ARSG 1940, p.263, assembled from table.

⁷¹ See ARSG 1930, p.344 and 1931 p.388.

⁷² In 1931, when the Great Depression was bottoming out, Army & Navy had to put beds on the verandas to handle the large number of VA patients. Impoverished men were claiming their veterans benefit; they may not have needed the hospitalization, but it meant three meals a day. ARSG 1931, p.378.

⁷³ ARSG 1923, p.249, table.

⁷⁴ AMSC, pp.54, 56, 57.

⁷⁵ See ARSG 1924 and 1925.

⁷⁶ ARSG 1924, pp.325-6.

VA funds, leaving only 433 Army employees and 169 VA employees in Army hospitals.⁷⁷ The Army also ceased training programs in OT and PT.⁷⁸ In 1934, a new organization began to buy space in Army hospitals, the Civilian Conservation Corps.⁷⁹ (The CCC was a New Deal organization to put unemployed men to work on public infrastructure projects.) By the end of the 1930s, utilization had stabilized. Of the roughly 5,000 Army hospital beds, the VA was filling 1,000 and the CCC 800-900 – while Active Duty patients filled only 1,500.⁸⁰ On a daily basis, there were likely almost as many empty beds as active duty patients, so without taking other government patients, there would have been political pressure to shrink the AMEDD to its “necessary” size. The OTs employed by the AMEDD might stand as a snapshot of the Army’s rehabilitation capabilities. There were nine OTs; two were paid for by the CCC, six by the VA, and only one was paid from AMEDD funds.⁸¹

Mobilization Plans

Interwar mobilization planning had only been plans, with no real tests due to lack of manpower and funds. Moreover, much of the emphasis was on industrial planning. In 1939 the Army overhauled its plans into a Protective Mobilization Plan, which accepted the small state of the AMEDD by expecting to use VA, PHS, and Indian Medical Service hospitals to supplement the small Army system.⁸² This does not seem to have been implemented beyond using VA hospitals, as discussed below, but it was an effort to utilize federal resources.

With the limited draft and the mobilization of the National Guard in 1940, the situation changed. By the end of FY1941, the AMEDD had 6,357 CONUS general hospital beds, up about 20%.⁸³ But that was far from enough for a much larger Army. VA patients were transferred to VA hospitals. Moreover, the Army considered at transferring Army patients out faster. Tuberculosis patients who would be not fit for duty were

⁷⁷ ARSG 1933, p.3. Most of the remaining VA-paid workers were at Fitzsimons, the TB hospital.

⁷⁸ Ritchie Hardwick, AMSC 45th Anniversary.

⁷⁹ The CCC would also pay for some civilian employees. AMSC, p.92.

⁸⁰ E.g. ARSG 1939, p.251.

⁸¹ AMSC, p.97. According to one source, only three of the nine were fully qualified. A.F. Mastellone, “Physical Medicine in the Army: History and Development,” Military Medicine (Sept. 1959), pp.641-45.

⁸² Marvin Kreidberg and Merton Henry, History of Military Mobilization in the U.S. Army, 1775-1945, (Washington, DC, GPO, 1955), p.490.

⁸³ ARSG 1941, p.254, assembled from table.

handed to the VA even though they were not maximally improved. Chronic disability cases were transferred to the VA, again, ahead of maximal improvement.⁸⁴ The Army also took some half-steps towards preparing for rehabilitation: some physicians were given short courses so they could head PT services at hospitals, and PTs were also enrolled in the Red Cross reserves against a wartime need.⁸⁵ To free up space for active-duty patients, the Army sharply curtailed care for dependents: they could receive outpatient care, but only emergency cases would even be considered for inpatient care, and only at the General Hospitals.⁸⁶ The AMEDD was squeezed for space, and was doing everything it could to expand the system and to reduce demand.

The VB/VA hospital system: developments

From a standing start in 1921, the VB built up a substantial hospital system, indeed the nation's largest, by 1940. While the VB/VA cared for veterans in various ways (including domiciliary homes like today's Soldiers' Home, medical devices, benefits, and vocational training), the focus here will be on the hospital system.⁸⁷ The Army, along with other federal organizations, would help the VB/VA, although never in a major way. For instance, while the Army provided 3,000 beds and 558,542 patient-days of care in FY1922, that was only 5% of the VB's overall hospital activity.⁸⁸ Over time, the Army's support to the VB/VA waned, especially as Congress was generous in funding veterans' hospitals; as early as FY1924 over \$35 million was appropriated for construction, and in 1931, even after the Great Depression started, Congress provided another \$20.9 million.⁸⁹

The Army provided beds, but from the VB/VA perspective it was a small and declining colleague. From using 3,000 Army hospital beds in the early 20s, the VA drifted down to the low 2000s by the end of the 20s and was less than 2,000 in 1934. By 1940 the Army was only providing 705 beds to the VA, about 1% of the VA's use of

⁸⁴ ARSG 1941, p.253. "Chronic disability" is not defined, but may have meant patients who would never RTD.

⁸⁵ AMSC, p.66

⁸⁶ AG memo, subj Medical care of dependents during the national emergency, 18 Dec 1940.

⁸⁷ For a contemporaneous overview of the VA, see Gustavus Weber and Laurence Schmeckebier The Veterans' Administration, its history, activities and organization (Washington, DC: Brookings Institution, 1934). For a somewhat flattering internal history, see Robinson Adkins, Medical Care of Veterans (Washington, DC, GPO, 1967) (hereafter MCV) which mentions other benefits while emphasizing medical care.

⁸⁸ ARVB 1922.

⁸⁹ ARVB 1924, ARVA 1931.

federal beds, and since the VA could use non-federal beds the Army was a very small element indeed of total VA hospitalization.⁹⁰ These numbers are obviously a small fraction of the VA's own capacity: from 20,000 to 54,000 beds.⁹¹

If the Army only handled a small percentage of the veterans, it also handled a skewed group. The veterans' hospitals had three general categories of patients: tuberculosis (TB) who generally stabilized or died, neuropsychiatric (NP) who recovered slowly if at all, and general medical and surgical (M&S) who usually recovered fairly quickly.⁹² The percentages changed over time, but were heavily weighted to TB and NP cases; lacking drugs to treat the conditions, these patients stayed in hospitals, indeed for years. The following table gives some idea of the changing veterans' hospital population:⁹³

Patients in veterans' hospitals, by diagnosis, percentages

Year	TB	NP	M&S
1922	40	35	25
1924	40	40	20
1926	37	37	26
1928	25	50	25
1932	15	46	39
1936	11	58	31
1940	8	58	34

The decline in TB patients reflects their disease either stabilizing or the patient dying; M&S climbed in the mid-20s after non-service-connected patients were allowed in, and again in 1932 when the domiciliary homes (effectively nursing homes for indigent elderly veterans) were rolled into the VA. What is noticeable is the dramatic percentage of psychiatric beds operated for veterans; in 1936 the VA was operating over 33,000 NP beds, almost certainly the world's largest system of asylums.

Out of this veteran population, the Army handled only a few psychiatric cases (and those mostly in the 20s), a good number of TB patients at Fitzsimons, and M&S cases scattered around the country. For instance, in 1922 the Army beds for VB use were

⁹⁰ ARVB 1922, 1928, ARVA 1934, 1940.

⁹¹ ARVB 1922, 1928, ARVA 1934, 1939.

⁹² The duration of stay by patient type was not always monitored, but by the late 30s medical-surgical patients were staying about 1.75 months, neuropsychiatric patients 2-2.33 years, and the average patient stay was 4 months. ARVA 1938.

⁹³ ARVB/VA for the relevant years. These percentages do not reflect the percentages of patients treated, for medical-surgical patients would be treated and discharged, but they are end-of-FY snapshots. This is the most consistent data available in the VB/VA annual reports and is thus used here.

40% TB and 60% M&S; in 1929 it was 38% TB, 13% psychiatric, and 49% M&S.⁹⁴ Thus the Army developed negligible expertise with long-term psychiatric patients; expertise with TB was largely limited to Letterman; and medical-surgical patients were frequently on a space-available basis and not supporting the Army's still rudimentary GME program.

Moreover, the VA was focusing on a particular set of patients: WWI veterans. Despite military retirees (and those discharged due to sickness or accident) and opening the VA to retirees of all wars, in 1941 90% of VA patients were WWI veterans.⁹⁵ Only 5% of patients were retirees or discharged, and the VA paid attention to its majority shareholder. This was also long-standing. When the VB formed a Medical Council in 1924, it urged R&D money be spent on chronic and geriatric conditions, knowing the government would be caring for these patients for years. Administrator Frank Hines had been in office since 1923, and clearly was skilled at getting money out of Congress: he got over \$17 billion over his 22-year career.⁹⁶ Longevity in office also meant Hines knew his system thoroughly, but he was a tremendous centralizer and grew set in his ways.⁹⁷ For instance, in 1923 there had been opposition to VB hospitals affiliating with medical schools, due to concerns that students would use the veterans as guinea pigs.⁹⁸ In 1944, with the VA suffering a serious shortage of medical staff, Hines quashed a proposal to bring in medical students and interns who could help out during their training.⁹⁹ Hines also opposed extensive research.¹⁰⁰

In 1941, on the verge of war, the VA was helping the Army in various ways. VA hospitals were taking X-rays and EKGs of draftees, and interpreting them for physicals. Beds were provided until the Army could build hospitals in training camps – even whole wards were provided at Fort Custer, MI, and Kecoughtan, VA. The VA lost a number of

⁹⁴ ARVB 1922, 1929. This data was not presented in the annual reports later, and the inference on later neuropsychiatric cases is based on silence in ARSG reports.

⁹⁵ ARVA 1941.

⁹⁶ MCV p.182. This was total VB/VA spending and thus included pensions etc. It also shows the clout of the American Legion, VFW, DAV, etc, and suggests Hines was effective in handling them. There is no biography of Hines, although his papers are at the U.S. Army Military History Institute.

⁹⁷ MCV p.195.

⁹⁸ MCV pp.116-7.

⁹⁹ MCV p.181. However, the VA's distorted patient population would make GME more difficult.

¹⁰⁰ MCV pp.182-3.

doctors who were Army Reservists.¹⁰¹ From September 1940 the VA made beds available to support Army maneuvers, and the VA was told that it would take patients that the Army could not rehabilitate.¹⁰² Meanwhile, the VA was expecting to expand to 100,000 beds (hospital and domiciliary combined) by 1950, and when the draft started it argued to have that number expanded because 1)it would not be getting short-term help from the military while 2)the number of future veterans was being expanded.

In summation, by 1941 the VA had a hospital system much larger than the Army's, had significant experience in handling psychiatric patients, but was heavily focused on an aging patient population.

¹⁰¹ ARVA 1941.

¹⁰² MCV pp.158-9.

Chapter 3

World War II

Introduction

Through the interwar years, the Army and VB/VA had had diverging patient populations. While the Army's population refreshed with new soldiers and stayed relatively young, the veterans aged. With different responsibilities, each organization's interests gradually diverged. WWII would be a major event for the VA, but the VA had its existing foci and pressure groups. Moreover, unlike the Army dropping responsibility for family members in December 1940, the VA would not be relieved of any of its responsibilities. Instead, the VA had to treat its existing patients (the routine medical and surgical patients and the semi-custodial TB and psychiatric patients), then the GIs who were discharged during the WWII mobilization, then the combat casualties. In 1945, the combat wounded would overstretch the VA and lead to national embarrassment and a major overhaul of the VA.

Some of the problems that would be breathlessly reported in the press in early 1945 were not specific to the VA. Advances in medicine and surgery were keeping more patients alive, and more severely wounded ones as well. For instance, burn care advanced by leaps and bounds in WWII, as did care for paraplegics; these patients would then be in hospital longer. The survival of more patients, who were also more debilitated, spotlighted the national lack of rehabilitation care.

The Army also implemented a substantial physical medicine program, starting from almost nothing as the specialty hardly existed. It also focused first on "reconditioning" RTD patients, convalescents, with the goal of conserving the fighting strength rather than "rehabilitation" for patients to be discharged.

Meanwhile, the Army had its own expansion problems. Surgeon General James Magee focused largely on mobilizing and training personnel and obtaining facilities. Not a man of vision, he also lacked the confidence of General George Marshall; in 1942 when public criticism of the AMEDD grew, an investigating committee tackled not only administrative problems, but gave advice on clinical policies. Surgeon General Norman Kirk tackled both sets of problems from 1943. He was undoubtedly helped by the momentum for change generated by the Waddhams Committee. However, the timing of

casualties (most wounded were evacuated to the US in late 1944 and 1945) strained the AMEDD. That strain was exacerbated by recognition that the Army had to keep complex patients instead of sending them to the VA because the VA could not provide adequate care.

The Army had to provide much more care because medicine had advanced to a point that more was possible. Late in 1944, President Roosevelt (presumably anticipating public concern) requested the Army to do everything possible. The Army responded that the VA was, by law, responsible for some functions – but also that it was already doing what it could. The Army still engaged in “resocialization,” roughly analogous to the reintegration that units go through today, albeit focused on patients. The American public was of two minds: some diseases and problems (especially psychiatric problems) were not to be spoken about but there was growing openness for some situations. The 1946 movie “The Best Years Of Our Lives” won seven Oscars for dealing with veterans returning home, and presented a bilateral hand amputee sympathetically. Harold Russell, formerly a sergeant, would receive two Oscars, one as best supporting actor and one “for bringing hope and courage to his fellow veterans.”

The Gradual Mobilization

As the war in Europe became more of a threat to the US, the government responded by expanding the military. The Navy laid down dozens of ships; the National Guard was mobilized and conscription was instituted, expanding the Army. These moves raised the question of medical care for the new personnel, both during the mobilization and in a potential conflict. The Federal Board of Hospitalization¹⁰³ drew up federal policy: the armed services would not try to cure patients, but only treat them and pass stable patients on to the VA for any long-term recovery. Certain categories of patients would be quickly passed to the VA (e.g. TB and NP patients), while amputees would receive temporary limbs (which would speed both their physical and mental recovery) but the VA would be responsible for permanent limbs. No particular provision was made for the blind. Length-

¹⁰³ Created in 1924 to coordinate Federal hospital facilities. It consisted of the Surgeons General of the Army, Navy, and PHS; the Administrator of the VA and another VA representative; the Superintendent of St. Elizabeth's; and the Solicitor General. It made recommendations directly to the President that were generally approved, then coordinated across the government by the Bureau of the Budget (predecessor of the Office of Management and Budget), but appropriations of course came from the Congress.

of-stay was a planning factor; since the Army would not hold patients for long periods, it would need fewer GH beds.¹⁰⁴ During the mobilization before Pearl Harbor the VA would pull its patients from military hospitals (clearing those beds for military patients), help with Selective Service physicals, and help if training exercises happened near a VA hospital.

That was agreed in July 1940, and signed in September. President Franklin Roosevelt approved the Army discharging patients on Certificate of Disability for Discharge who would go straight into VA hospitals.¹⁰⁵ In effect, Roosevelt was overriding regulations, because AR 615-360 still described patients staying the Army until they received “full benefit of hospitalization.” This would effectively make the VA into Echelon VI. Yet now the VA would receive non-RTD men for physical rehabilitation. This would stay the policy into the war. The FBH’s first wartime meeting was 24 December 1941, and the first item discussed was how soon the military would transfer non-RTD patients. The only answer Surgeon General Magee could muster was “the solution of the hospitalization problem is not apparent at present and that he thought it was a matter that would have to be explored.”¹⁰⁶

The Hospital Systems

The VA

From 1942 to 1945 the VA added hospitals and beds, largely in conformity with the 1940 plan to have 100,000 beds by 1948. Congress had already appropriated large sums for the planned expansion, and money was not an issue for the increased wartime expansion plans. (Materials were a bottleneck, since the war effort needed building materials and the VA was not declared “an essential war agency” until mid-1944, and even then it stayed behind Army and Navy in priorities.) From 56,000 hospital beds in 1942, it expanded marginally in 1943, then to 64,000 in 1944 and 71,500 in 1945.¹⁰⁷ Due to wartime construction bottlenecks, little of the expansion was new facilities but instead expansion of existing ones e.g. by putting beds on verandas. Two nursing homes were

¹⁰⁴ Clarence Smith, The Medical Department : Hospitalization and Evacuation, Zone of Interior, (Washington, DC: GPO, 1956), (hereafter H&E:ZI), p.13.

¹⁰⁵ See resolution, FBH, 16 July 1940. RG51, entry 3, box 12. (All FBH records are in RG51, entry 3. Subsequent references will be to the particular box.)

¹⁰⁶ FBH minutes, 24 December 1941, box 8.

¹⁰⁷ ARVA, appropriate years. These figures are rounded from the end-of-year beds occupied, and exclude domiciliary facilities like the Soldiers’ Home.

also converted into NP hospitals.¹⁰⁸ The GI Bill provided \$500 million for future VA hospitals, but since it was passed in mid-1944 it would have negligible impact during WWII.¹⁰⁹ Another problem, beyond the shortage of materials and workers, was the parsimonious government mentality. Instead of spending on a potential future problem (which could have attracted immediate Congressional and public condemnation as waste), the VA planned to take over hospitals built by the Army and Navy. This would avoid over-spending in the long run, but at the risk of capacity crises at some point during the war if casualties exceeded the VA's capacity before the military transferred hospitals.¹¹⁰

Moreover, the VA knew it would be facing not just casualties, but a vastly increased future beneficiary population. Roughly 4 million served in the Army in WWI, while 16 million served in the armed forces in WWII; even providing the same level of services to the new veterans would require a vastly-expanded VA. Changing the beneficiary criteria could reduce that number, and until March 1943 the VA was only required to treat service-related conditions for WWII veterans (others were on a space-available basis if the veteran could not afford private care) but all conditions for pre-WWII beneficiaries. Afterwards, all veterans were treated equally, equitable but a further burden on the VA.¹¹¹

To round off one point, in March 1943 the VA was again put in charge of vocational rehabilitation of veterans.¹¹² This replicated the decision ultimately reached in WWI, that it was not a military responsibility, and has remained a VA responsibility since.

The Army¹¹³

If the VA hospital system expanded during WWII, the Army's system exploded. There were approximately 6,000 general hospital beds at the end of 1940, 18,000 in 1941,

¹⁰⁸ MCV, p.167.

¹⁰⁹ MCV, p.170. The Army spent roughly \$1 billion on CONUS hospital construction during WWII.

¹¹⁰ ARVA 1942. The VA warned against repetition of the post-WWI experience, which had seen wartime temporary buildings handed over for long-term use. H&E:ZI, pp.74-5.

¹¹¹ MCV, pp.168-9.

¹¹² 50 Years of Vocational Rehabilitation, p.12. Vocational rehabilitation advocates had tried to get Federal funding for civilian rehabilitation, saying that the rehabilitated would expand the wartime labor pool, but Congress would not fund it until veterans were included.

¹¹³ H&E: ZI covers the Army hospital system in detail; this is only a brief overview.

28,000 in 1942, 50,000 in mid-1943, 80,000 at the end of 1943, 110,000 at the end of 1944, and 155,000 in mid-1945.¹¹⁴ Factors were the growth of the Army, treating more casualties, and retaining long-term patients instead of sending them to the VA.¹¹⁵ From early 1943, GHs also became specialized in treating certain kinds of patients, for example psychiatric or general surgery or tropical medicine. From 1944, reconditioning/rehabilitation programs were added at many hospitals, typically in existing buildings; most of the programs were graduated calisthenics rather than complex physical therapy regimens.

In addition to this expansion, the Army created two new categories of hospital in 1944, convalescent hospitals and regional hospitals. Convalescent hospitals are self-explanatory, but regional hospitals were to take the complex sick and injured from CONUS. (A pledge had been made that all patients returned from overseas would be sent to GHs. The RHs provided more specialized care for CONUS patients, leaving GHs for overseas patients.) Regional Hospitals started in June 1944 at 70,000 beds, contracting to 56,000 in December. In mid-1945 there were 52,000, declining by December 1945 to 40,000, and in mid-1946 only about 24,000 beds. Convalescent Hospitals had 19,000 beds in mid-1944, 38,000 at year-end, 60,000 in mid-1945, then contracted to 20,000 at the end of 1945 and only 5,000 in mid-1946.

All these hospitals, plus the hundreds of station hospitals, required materials and money; the Army spent approximately \$1 billion on CONUS hospitals during the war. Many were strictly temporary, and most of the rest were semi-permanent construction to save time, labor, and materials. Only a few were permanent fire-proof construction that met the standards Congress had established for VA facilities. As in WWI, some buildings were taken over for hospital use; these included existing hospitals and hotels.

¹¹⁴ Numbers in this section are drawn from graphs in H&E, ZI and are approximate because of being drawn from graphs.

¹¹⁵ H&E: ZI, p.80.

Personnel

The VA

If the VA was somewhat successful in getting resources for facilities, it lost heavily in the manpower needed to run them.¹¹⁶ The U.S. drafted men for military service, not national service, so the VA gained patients but lost employees. (Lack of manpower would have affected quality of care if new facilities had been completed.) A number of the VA's medical professionals were military reservists, and they were called to the colors, although by June 1942 the War Department let the VA keep its remaining reservists.

Hiring more doctors was not an easy solution, even if they were available during the national mobilization. Civil Service hiring rules forced the government to show cause when not hiring people who had been accepted onto a master list as qualified. In 1945, the top name on the list for physicians was 87 years old, and the second person was 76 years old. The majority of the top 80 were over 60, and some had been institutionalized for insanity or alcoholism.¹¹⁷

In addition to doctors and dentists, the VA lost roughly 7,000 workers who were either drafted or left for more lucrative work. By late 1943 the VA negotiated an agreement with the Army to release a few doctors, and a few others from active duty were lent to the VA; it rose to a high of 1,566 physicians during the war.¹¹⁸ In 1944-45 further aid was achieved by sending 1,200 men from the Army ASTP and the Navy V-12 programs to serve their internship in VA hospitals, and cadet nurses were also employed.¹¹⁹ During the war the Army also lent 8,000 enlisted personnel.¹²⁰

The Army¹²¹

During WWI, the draft had included all males, including enemy nationals, and made no special provision for physicians. Lobbying by the AMA and other professional

¹¹⁶ MCV, pp.166-7, 170, 178; Charles Griffith MD, "Medical and Hospital Service Experience with Disabled Veterans of World War II," in William Brown Doherty MD and Dagobert Runes PhD, eds, Rehabilitation of the War Injured: A Symposium (New York: Philosophical Library, 1943), pp.503-504.

¹¹⁷ MCV, p.210.

¹¹⁸ It is not clear when this figure was achieved. MCV does not give a date, and ARVA does not give employment details.

¹¹⁹ MCV, p.170, John H. McMinn and Max Levin, Medical Department, United States Army: Personnel in World War II, GPO, 1963, p.203.

¹²⁰ MCV, p.178.

¹²¹ This section no more than hits the highlights of a complex subject. For real depth, see both McMinn and Levin, Personnel in World War II, and Robert Parks, Medical Department, United States Army: Medical Training in World War II, Washington, DC: GPO, 1974.

organizations exempted doctors during WWII, but around 50,000 physicians eventually served in the Army, plus 15,000 dentists, and thousands of other medical professionals. Tens of thousands of nurses also volunteered, and a draft was specifically considered by both the War Department and Congress; the House of Representatives had approved a bill drafting nurses and it was in Senate committee when the fighting ended. Occupational and physical therapists (both fields still dominated by females) had to be volunteers, and went through personnel shortages; PT strength peaked at just over 1,000. PTs were assigned overseas (to rear-area hospitals), but because OTs were civilian employees and were in short supply, they were not sent overseas.¹²² The draft meant obtaining enlisted men was not a problem, and peak strength reached 570,000, but personnel quality and skills could be troublesome. Women's Army Corps personnel were substituted (some qualified from civilian experience and some after military training) for men, Negro personnel were used (generally for unskilled labor), and Limited Service personnel were assigned in large numbers.

These large numbers can be deceiving. The Army had shortages of some specialties, for instance psychiatrists. There was no way to fully train a psychiatrist during the war, so short courses were devised to provide some training. Another problem was getting the right man in the right job, and the specialty boards were approached for advice.¹²³ Once specialists had been identified, the Army had problems getting them in the right places. The organization of Army Service Forces (to parallel Army Ground Forces and Army Air Forces) meant a layer of bureaucracy between the AMEDD personnel officers and the CONUS hospitals; ASF officers had trouble understanding what sort of physician to assign where. That made it difficult to organize specialty treatment centers. In short, while the Army had some personnel problems, it had an easier time than the VA both for quantity and quality of personnel.

¹²² AMSC, pp.259-66, 331. Supply of OTs was short enough that in mid-1944 a government-subsidized course was established that would graduate 545 students in mid-1945. Mastellone, "Physical Medicine in the Army: History and Development."

¹²³ This was the origin of the letter designators, so that (say) a board-certified general surgeon was not confused with a physician who had done some general surgery.

Developments of policy and practice

1942 would see problems for the Army, the VA, and the federal policy coordinating them. The Army was mobilizing as fast as it could, but believed it could have high manpower standards; after all, the draft was operating, and there were millions of men available. As a result, the Army discharged tens of thousands of men, mainly NP patients, although there were TB and M&S (including wounded) as well. However, given the low number of troops in action, there were few wounded to treat, and the major ground operations of 1942 (the TORCH landings in North Africa) did not begin until November. Since hospitals in theater would hold patients until stable, the number of wounded getting back to the CONUS GHs was very small.

The biggest event for the AMEDD was administrative. The AMEDD had attracted public criticism, and its administrative problems caused concern elsewhere in the War Department, so in September 1942 an investigative committee was appointed under a retired Medical Corps colonel, Sanford Waddhams.¹²⁴ The Waddhams Committee had eight physicians and only one hospital administrator, and made many recommendations, both clinical and administrative. Administrative topics included speeding up CDD paperwork, and the Army response was to delegate that authority to commanders of posts with over 5,000 men.¹²⁵ A quasi-administrative, quasi-clinical recommendation was to implement convalescent programs to toughen soldiers who would RTD, and also to establish convalescent hospitals. From February 1943 the Army implemented programs to bridge the gap between hospital beds and full duty, but at that point it was dubious about hospitals; there would only be convalescent groups at General Hospitals, not separate facilities. Buried among other recommendations was the bombshell: the Army should only transfer to the VA its NP cases and those that had received definitive treatment. That an advisory committee made a recommendation with such far-reaching implications suggests that the FBH policy had not rooted itself deeply into the AMEDD, and also that civilian doctors (possibly more accustomed to treating a patient through to recovery) did not see the Army hospital system as echelons of care.¹²⁶

¹²⁴ For more on the Waddhams Committee, see Blanche Armfield, Medical Department, United States Army: Organization and Administration in World War II, GPO, 1963, pp.145-185.

¹²⁵ There had already been some steps to simplify this in 1940 and early 1941. H&E:ZI, pp.35-36, 127-8.

¹²⁶ I have highlighted recommendations 12, 14, 24, and 29; there were 87 all told. "Actions on Recommendations," on file, OMH.

On 31 March 1942 there were only 495 WWII veterans in the VA hospitals, hardly surprising since the disposition boards would barely have had time to discharge a LOD patient from the military. The number would rise through the year, but never be significant; through 1 September 1942, the VA admitted 4,377 WWII patients, 43% M&S, 34% TB, and 23% NP.¹²⁷ The VA was looking ahead, and asking the War Department for forecasts of how many patients the VA could expect in 1943 and 1944. The answer was 10,000 for 1943 and 25,000 for 1944.¹²⁸ These were obviously rough estimates, but include NP and TB cases; if these numbers were actually used as planning factors, they would have distorted that planning. In fact, the VA expected to get NP and TB patients early in the war, which allowed time to establish capability to treat the wounded.¹²⁹ However, by the end of 1942 there was little sign of the VA addressing rehabilitation of the wounded; its planning extended to more of the same rather than expanding programs.¹³⁰ For the year, 88% of VA patients were WWI veterans, and a further 6.8% were Spanish-American War veterans. As befitted such a beneficiary population, the VA focused its physician education on geriatric problems: cardiovascular disease, cancers, and prostate problems.

1943 saw further changes. For the Army there was a new Surgeon General, MG Norman Kirk, and he started new policies on care, including convalescents. The VA, in contrast, lacking resources to change (and possibly lacking the leadership) largely continued on auto-pilot.

One major decision for the Army was how to deal with the Waddhams recommendations. In February 1943, the FBH had avoided a decision, leaving it to the service Surgeons General to decide how long to treat patients, so long as interruption in treatment would not adversely affect the care a patient received.¹³¹ Through April the

¹²⁷ Griffith, op. cit., pp.498-504. For an overview of early physical medicine and rehabilitation, see F.H. Krusen MD, "Historical Developments in Physical Medicine and Rehabilitation During the Last Forty Years," Archives of Physical Medicine (January 1969), pp.1-5.

¹²⁸ Cited in ltr, Administrator of VA to SecWar, 29 Jan 1943, in Waddhams Committee files, OMH, "Actions on Recommendations." 50% of patients would be medical-surgical, 30% neuropsychiatric and 20% TB.

¹²⁹ FBH resolution, 9 March 1942, Box 12.

¹³⁰ Charles M Griffith MD, "Medical and Hospital Service Experience with Disabled Veterans of World War II," Military Surgeon, (Feb. 1943), pp.135-140.

¹³¹ FBH minutes, 3 February 1943, box 8.

Army even mulled a directive that no patient be transferred “as long as there is any additional care that can be given.”¹³² It is not clear if that hopelessly vague standard was ever implemented, but it could have left the Army never turning a patient over to the VA. In fact, a similar policy that even the official history acknowledged was reached “rather informally” (patients to reach maximum improvement before handover to the VA) did lead to very long hospitalizations for several reasons.¹³³ Patients felt the Army offered better care; their military pay would be higher; and they wanted maximum improvement from the Army. Doubtless some patients preferred to stay in a known environment and liked the military culture. However, there were still areas where the AMEDD drew the line: TB, psychotic, and non-LOD cases were still sent to the VA.¹³⁴ Since the AMEDD was unwilling to annoy most soldiers by discharging them, and hospital space was finite, alternatives had to be found. Consultants and OTSG inspectors toured hospitals to press doctors to discharge patients; patients were also put on leave or on furlough and could even take a job.

Another change the Army implemented in March 1943 was specialty treatment centers. Specialist personnel were concentrated at certain general hospitals and patients brought to them; it was an organizational plan to solve clinical problems. Amputees received special attention. The initial plan, based on the FBH plan, was for the Army to provide temporary prostheses and promptly send patients to the VA for definitive prostheses.¹³⁵ Again, the VA’s personnel problems meant poor care, and by August the Army was keeping its amputees until they received maximum benefit of hospitalization.¹³⁶

In 1943, the VA had 4,200 WWII vets as “first admissions” (neither returning for the same problem nor transferred within the VA system), and an unknown number were

¹³² MFR in “Actions on Recommendations.”

¹³³ John Coates, ed., Medical Department United States Army, Surgery in World War II, Activities of Surgical Consultants, vol.1, (Washington, DC: GPO, 1962), p.51; Orthopedic Surgery ZI, pp.65-67.

¹³⁴ H&E ZI, p.241.

¹³⁵ SGO Circular Letters 91 (25 April 1943) and 115 (25 June 1943). Circular Letters were the predecessors of TBs MED.

¹³⁶ Orthopedic Surgery ZI, pp.849-1014 covers both clinical and administrative aspects of the amputation program.

admitted straight from Army hospitals.¹³⁷ In July, the VA began sending representatives to the National Research Council's orthopedic surgery committee; the VA recognized it would have responsibility for orthopedic patients (especially the amputees) for the future.¹³⁸ That the VA had not been participating in the meetings since 1940 is perhaps the more remarkable point, especially since Administrator Hines wanted the VA to take patients from the military. Yet the whole WWII workload was only 7.4% of the VA's activities. The first steps were being taken towards rehabilitation, with 18 physicians being sent on a training course in physical medicine, but the VA was also building a cancer hospital to care for its own long-term patients.

1944 would see the Army grappling with repercussions from its decision not to hand patients off to the VA. It would also see the VA getting closer to its own publicity problems.

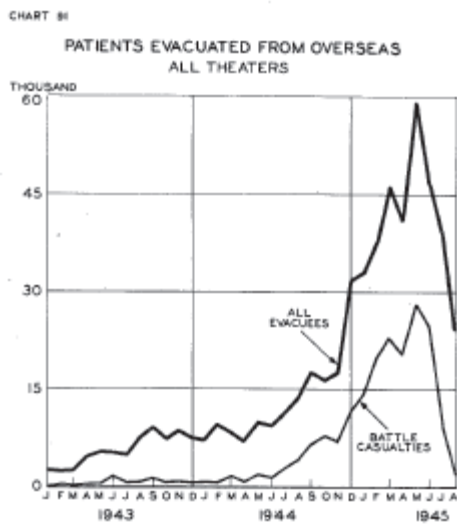
The first months of the year saw relatively little change in Army hospitals because the flow of battle casualties was still modest, about 9,000 casualties per month. (The major combat operations were in Italy, including the Anzio beachhead and fighting at Monte Cassino.) Even for several months after D-Day casualty flows did not substantially increase. First, the hospitals in England had to get the patients stable, and second the European Theater Surgeon (MG Paul Hawley) deliberately held patients to keep his hospitals and physicians busy and because he felt only fully-staffed and fully-equipped hospital ships (as opposed to using empty transports ships reinforced with limited medical-surgical assets) were good enough.¹³⁹ Hawley's actions embarrassed Surgeon General Kirk, who had to explain why GHs in CONUS were largely empty when everyone knew there were thousands of casualties. Once the Germans counterattacked in the Battle of the Bulge, Hawley had to precipitously empty his

¹³⁷ ARVA 1943. For some time the Army discharged all CDD patients to a VA hospital, which might hold them as little as one night; the VA managed to get that waste of effort stopped. No breakdown of NP, TB, and M&S has been found.

¹³⁸ Orthopedic Surgery ZI, p.42

¹³⁹ Interview, Dr. Eli Ginzberg, 10 Sept. 1963, paras.27-8. Ginzberg was a civilian management expert who had joined the AMEDD in the aftermath of the Waddhams investigation. See also William Mullins, ed., Medical Department United States Army, Surgery in World War II, Orthopedic Surgery in the Zone of Interior (Washington, DC: GPO, 1970), pp.257-8, (hereafter Orthopedic Surgery ZI) and H&E:ZI pp.235-37.

hospitals to accommodate the sudden rush of casualties, an action which caused fresh embarrassment because it was a complete reversal of policy.¹⁴⁰



Army Service Forces Statistical Review, Statistics Branch, Control Division, HQ, ASF, War Department, [1945?], p.69.

¹⁴⁰ The increased number of casualties also caused a shortening of the evacuation policy, meaning still more patients were sent back to CONUS.

TABLE 16—PATIENTS DEBARKED IN THE UNITED STATES, 1920-45

Date	Total Patients Debarked ^a	Returned by Water						Returned by air	
		Number	Percentage of Total Patients Debarked	Troop Transport		Hospital Ship		Number	Percentage of Total Patients Debarked
				Number	Percentage of Total Patients Debarked	Number	Percentage of Total Patients Debarked		
1920-40 ^b	15,846								
1941 ^c	2,390								
1942	9,248								
1943^d									
January	2,475	2,442	98.7	2,442	98.7	0	0	33	1.3
February	2,177	2,136	98.1	2,136	98.1	0	0	41	1.9
March	2,351	2,300	97.8	2,300	97.8	0	0	51	2.2
April	4,777	4,712	98.6	4,712	98.6	0	0	65	1.4
May	5,349	5,242	98.0	5,242	98.0	0	0	107	2.0
June	6,115	5,971	97.6	5,222	85.4	749	12.2	144	2.4
July	5,735	5,350	93.3	5,350	93.3	0	0	385	6.7
August	8,183	7,762	94.9	7,762	94.9	0	0	421	5.1
September	9,425	9,088	96.4	9,088	96.4	0	0	337	3.6
October	7,469	6,884	92.2	6,884	92.2	0	0	585	7.8
November	10,604	10,195	96.1	8,984	84.7	1,211	11.4	409	3.9
December	7,163	6,481	90.0	6,481	90.0	0	0	682	10.0
Total	71,823	68,563	95.5	66,603	92.8	1,960	2.7	3,260	4.5
1944									
January	7,724	7,179	92.9	6,018	77.9	1,161	15.0	545	7.1
February	9,763	9,220	94.4	9,220	94.4	0	0	543	5.6
March	8,894	8,172	91.9	6,458	72.6	1,714	19.3	722	8.1
April	7,082	6,249	88.2	4,994	70.5	1,255	17.7	833	11.8
May	9,652	7,965	82.5	4,462	46.2	3,503	36.3	1,687	17.5
June	9,712	7,532	77.6	6,125	63.1	1,407	14.5	2,180	22.4
July	11,593	7,547	65.1	4,841	41.8	2,706	23.3	4,046	34.9
August	14,060	9,708	69.0	8,044	57.2	1,664	11.8	4,352	31.0
September	21,383	15,860	74.2	11,515	53.9	4,345	20.3	5,523	25.8
October	20,894	17,085	81.8	11,530	55.2	5,555	26.6	3,809	18.2
November	19,700	16,846	85.5	11,665	59.2	5,181	26.3	2,854	14.5
December	32,511	28,115	86.5	21,393	65.8	6,722	20.7	4,396	13.5
Total	172,968	141,478	81.8	106,265	61.4	35,213	20.4	31,490	18.2
1945									
January	33,382	29,329	87.9	26,191	78.5	3,138	9.4	4,053	12.1
February	38,251	31,989	83.6	26,814	70.1	5,175	13.5	6,262	16.4
March	44,854	36,387	81.1	31,210	69.6	5,177	11.5	8,467	18.9
April	43,839	34,650	79.0	26,982	61.5	7,668	17.5	9,189	21.0
May	57,030	46,099	80.8	36,545	64.0	9,554	16.8	10,931	19.2
June	45,168	34,228	75.8	26,778	59.3	7,450	16.5	10,940	24.2
July	36,873	24,547	66.6	15,379	41.7	9,168	24.9	12,326	33.4
August	26,258	17,469	66.5	9,575	36.5	7,894	30.0	8,789	33.5
September	19,780	12,393	62.7	8,007	40.5	4,386	22.2	7,387	37.3
October	19,618	14,944	76.2	10,081	51.4	4,863	24.8	4,674	23.8
November	13,138	11,061	84.2	3,489	26.6	7,572	57.6	2,077	15.8
December	7,781	6,121	78.7	572	7.4	5,549	71.3	1,660	21.3
Total	385,972	299,217	77.5	221,623	57.4	77,594	20.1	86,755	22.5

^a Figures through April 1943 include Army patients only; the remainder include in addition prisoner-of-war patients, some patients of Allied nations, and a few American Red Cross patients.

^b Figures from *Annual Report . . . Surgeon General, 1920-41* (1920-41).

^c Figures for 1941 and 1942 supplied by Medical Statistics Division, SGO.

^d Figures for 1943-45 from History . . . Medical Regulating Service . . . They were compiled originally from monthly reports of patients debarked, now located in SG: 705 "Evac Reqmts, Books I and II."

United States Army in World War II: Hospitalization and Evacuation, Zone of the Interior, p.324

A new responsibility was care of the blind.¹⁴¹ In May 1942 Surgeon General Magee responded to a question that he intended to follow the FBH policy and transfer blind patients to the VA as soon as possible. However, in June 1942 a committee realized that some care would have to take place while patients were healing from other wounds, not least what was called “social adjustment” training, on how they could cope in civilian life. In April 1943 the Army established specialized treatment centers, where the Army would treat the physical wounds and VA staff worked alongside but only about the blindness. However, by October 1943 a gap had opened: the VA lacked capacity to treat the numbers of blind awaiting discharge. Since WWI the VA had mainly administered pensions to the blind, doing little rehabilitative care, and the services decided they would have to do more for the blinded, through maximum benefit of hospitalization to social adjustment training and on to both activities of daily life (although the term does not seem to be in use then) and vocational training. On 8 January 1944 President Roosevelt ordered “No blinded servicemen ... would be returned to their homes without adequate training to meet the problems of necessity imposed upon them by their blindness.” The Army provided initial rehabilitation at two GH, then had a second-phase “personal and social adjustment rehabilitation training course” at one Convalescent Hospital; there was some rudimentary vocational training at the CH. Full vocational training was a VA responsibility. But the VA’s reputation and capabilities were such that patients wanted to stay in Army hospitals which delayed their transfer.

To round off care of the blind, there was a bureaucratic wrangle after the war. The Army could not reasonably care for blind patients, and there was doubt whether the existing laws allowed the VA to do anything beyond vocational training. Truman cut through the bureaucratic wrangle with a Presidential Order on 28 May 1947, assigning the VA all social adjustment training. (This has remained the case since.)¹⁴² The Army would discharge 4,473 blinded patients during the war, 292 of whom were totally blind in both eyes.¹⁴³

¹⁴¹ On blind care in WWII, see John Coates, ed., *Medical Department United States Army in World War II Ophthalmology and Otolaryngology*, (Washington, DC: GPO, 1957), pp.147-209.

¹⁴² www1.va.gov/blindrehab However, no such “Presidential Order” has been found.

¹⁴³ John Lada, ed. *Medical Department United States Army in World War II Medical Statistics*, (Washington, DC: GPO, 1976), pp.396, 726. Deafened patients were nothing like the problem of the blinded. Policy was that the VA would have ultimate responsibility but the Army would start treatment

It was the influx of patients from Europe that led to new categories of hospitals being created. The Regional Hospitals and Convalescent Hospitals (mentioned above) were established to free beds in the GHs. Regardless, until late in the year there was little change in policy. The VA was still considered second-rate, and that meant a backlog of patients in Army hospitals. Despite projections that every GH bed would be occupied in December, the Army was not going to send convalescents to the VA, even as it continued sending TB and NP cases.¹⁴⁴

The late change was due to a letter from President Franklin Roosevelt to Secretary of War Henry Stimson¹⁴⁵:

December 4, 1944

My dear Mr. Secretary,

I am deeply concerned over the physical and emotional condition of disabled men returning from the war. I feel, as I am sure you do, that the ultimate ought to be done for them to return them as useful citizens – useful not only to themselves but to the community.

I wish you would issue instructions to the effect that it should be the responsibility of the military authorities to insure that no overseas casualty is discharged from the armed service until he has received the maximum benefit of hospitalization and convalescent facilities which must include physical and psychological rehabilitation, vocational guidance, pre-vocational training, and resocialization.

Very sincerely yours,

Franklin D. Roosevelt

Stimson's reply¹⁴⁶ was a straightforward description of existing policy (psychotics and TB cases to the VA promptly, others to stay in the Army until maximum benefit reached), and he pointed out that the Army lacked resources for pre-vocational training and any legal basis to give vocational training. However, the AMEDD interpreted Roosevelt's letter to extend "maximum benefit" to all service-connected cases, not simply overseas casualties as the President mentioned.¹⁴⁷ However, it does seem to have caused hospitals to hold patients longer and longer, and in the spring of 1945 – as tens of thousands of patients arrived from Europe and the Pacific – Surgeon General Kirk had to

because many patients would be in hospital for considerable periods with other wounds. Moreover, 23% of a series in one of the specialty treatment centers would RTD. See Ophthalmology and Otolaryngology, pp.447-487 for details.

¹⁴⁴ FBH minutes, 17 Aug 1944, box 10. Ginzberg, in retrospect, thought the VA had trouble even with TB cases; interview, para.31. This may have been complex TB cases.

¹⁴⁵ Robert Anderson, ed. Medical Department United States Army, Neuropsychiatry in World War II, vol.1, Zone of Interior, (Washington, DC: GPO, 1966), p.291. Hereafter Neuropsychiatry: ZI.

¹⁴⁶ Neuropsychiatry: ZI, p.292.

¹⁴⁷ It is not clear if Roosevelt's letter was used by the AMEDD to support rehabilitation programs; the official history says it was used to gain resources for reconditioning of convalescents. H&E:ZI, p.190.

write to hospital commanders telling them to discharge patients that would not recover further.¹⁴⁸

In 1944 the VA's emphasis for new hospitals stayed on NP cases.¹⁴⁹ Most of the \$50 million appropriated that year was earmarked for NP hospitals, and 95% of the beds under construction were NP beds. (The mix of hospitals would be balanced taking over TB and M&S beds from the military.) The year also saw the first major rise in the VA's WWII hospitalizations, more than doubling; 21% of beds at year-end were occupied by WWII vets, with one-third of all admissions being WWII veterans. (This may have been because FY1944 was the first full year that non-LOD patients from WWII were eligible for VA medical care.) Yet with the year-end at 30 June, many of the admissions would not have been wounded but sick, injured, and NP cases from training. The snapshot from the end of the fiscal year still showed 63% NP cases, 27% M&S, and 10% TB, roughly the VA's interwar figures.¹⁵⁰ The VA was substantially upgrading its ability to handle wartime cases: tropical disease centers were created, NP hospitals were getting electroshock therapy equipment and doctors trained in pre-frontal lobotomies, and penicillin was becoming available.

1945 would see the most dramatic changes thanks to press attention, thousands of casualties arriving from overseas, and the end of the war. In 1942 public attention had sparked the Waddhams Committee investigating the AMEDD; now in 1945 the VA would come under press scrutiny with similarly embarrassing results. Weaknesses in the VA had been noticeable late in 1944, but the shortage of medical personnel, hiring rules, and probably Hines' management style exacerbated problems.¹⁵¹ Media exposés in early January 1945 led to public clamor over the VA's quality of care, and not for NP patients but for the heroic wounded.¹⁵² Hines was singled out for running a cheap operation, returning money to the Treasury instead of spending his full appropriation on care; a pair of magazine articles was titled "Third-Rate Medicine for First-Rate Men." The VA

¹⁴⁸ H&E:ZI, pp.241-2.

¹⁴⁹ ARVA 1944.

¹⁵⁰ These numbers do not correlate exactly with the table in Section II because they exclude the domiciliary beds, which were roughly 60% medical-surgical and 40% neuropsychiatric.

¹⁵¹ Ginzberg claimed that, before the 1944 election, he had warned Bureau of the Budget officials that the VA would end up causing a scandal. Interview, para.31.

¹⁵² See MCV, pp.171-5.

defended itself, drawing in its usual friends in the veterans' service organizations. Hines admitted that care had deteriorated, but blamed staffing shortages and continued to argue that the VA was necessary for casualty care, that "the line from the battlefield to Veterans Administration hospital is direct,"¹⁵³ and thus that the VA was an echelon of care.

However, voices in the medical profession had turned against the VA. The American Hospital Association, for instance, attacked not only the quality of VA care but its willingness to institutionalize patients instead of cure them.¹⁵⁴ With the public incited against the VA, and the medical profession not defending it, President Truman moved, saying "The VA will be modernized," thereby implicitly accepting it was outmoded. He appointed GEN Omar Bradley, with a reputation as a "soldier's general," to be the Administrator.

Some of the criticism was due to staffing levels, some to mediocre personnel. The decades-old policies of putting many TB and NP hospitals in geographically-remote areas put them outside the mainstream of American medicine. Combining geographical isolation with no funding for continuing medical education and many semi-custodial NP and TB patients, and it is hard to imagine many up-and-coming doctors in the VA.

There were also specifics of federal policy that had rational bases, but could be sensationalized in the press. For instance, the division between temporary prostheses (provided by the military) and permanent ones (from the VA) was a reasonable division of federal responsibility. However, the VA had trouble getting a prosthesis program going, especially as it seems to have waited until late in the war to start, and then was stuck with a policy of ordering the cheapest limbs, which essentially forbade the most advanced ones.¹⁵⁵ The public pressure was simply for the government to solve the problem, not about whether the military or the VA did so. The Army had more capabilities and in early 1945 it stopped thinking of the VA as the lead player on definitive prostheses.¹⁵⁶

¹⁵³ BG Frank Hines, "The Veterans Administration," Modern Hospital (February 1945), p.70.

¹⁵⁴ The AHA apparently was conflating the NP cases, for whom there was little cure available, with M&S patients. The AHA did have an economic interest; one possibility was sending veterans to private hospitals for care. Editorials, Modern Hospital, (January 1945) p.41 and (May 1945), p.42.

¹⁵⁵ MCV, pp.335-8.

¹⁵⁶ See Memo and report, COL Tracy Voorhees to SecWar, 9 Nov 1945, subj: Steps Required for Maximum Research Effort to Solve Problems of War Amputees (Voorhees Papers, MHI), and Arthur J Zobelein, "The Role of the Armed Forces in the Development of Artificial Limbs," unpublished paper,

Even during the tumult of public outcry, Congressional investigation, and new leadership, the VA continued operating. Fiscal 1945 (1 July 1944-30 June 1945) brought the effective end of WWII, and the worst of the public scandal, and saw the first dramatic changes in the VA. WWII patients were 30% of year-end hospitalizations, roughly a 50% increase over 1944, and were 47% of all patients during the year. Further, the absolute numbers had increased: the 30% represented almost 21,000 patients. Even before the new leadership team of Bradley and Maj. Gen. Paul Hawley (Chief Medical Director) arrived,¹⁵⁷ the VA was responding to the wounded patients it was receiving by setting up centers for amputee care and spinal-cord injuries, and almost all neuropsychiatric hospitals had electroencephalograph machines. The VA knew it needed more beds, and the planned building program would yield 108,407 hospital beds, 16,137 domiciliary beds, and 5,438 beds in other federal hospitals; future plans called for another 29,100 beds by 30 June 1948.

While the VA was facing public embarrassment, the Army was facing the flood of casualties from Europe. November 1944 had seen fewer than 20,000 patients returning, but that increased to 32,500 in December, rising steadily to 57,000 in May 1945.¹⁵⁸ They had to be put in emergency beds in GHs, and convalescent patients were furloughed, resulting in hospitals operating at over 100% patient capacity.¹⁵⁹ The end of the war may have saved the AMEDD from overloading. Less combat caused fewer patients, and the hospitals in Europe no longer needed to keep beds empty for future casualties. In CONUS the numbers hospitalized crested in mid-1945, then dropped rapidly.¹⁶⁰ The atomic bombs also helped by obviating the casualties concomitant to an invasion of Japan.

Demobilization¹⁶¹

While caring for the tens of thousands of wounded, the Army also dealt with a major demobilization. Almost from the German surrender, troops were clamoring for release to

MHI. While Voorhees' papers have next to nothing on the VA, as an Army officer he might not have received paperwork showing the VA's activities.

¹⁵⁷ Bradley took office 15 August 1945, and Hawley 15 September.

¹⁵⁸ H&E: ZI, table, p.324.

¹⁵⁹ H&E: XI, chart, p.212.

¹⁶⁰ H&E:ZI, charts pp.211-2.

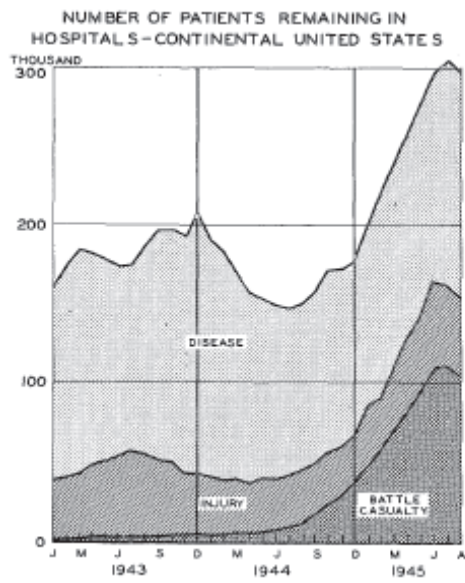
¹⁶¹ For more details, see H&E:ZI chapter XVIII and Personnel chapter XIII.

civilian life, and since they were citizens and voters, Congress was sympathetic. (Congress showed some special sympathy to medical personnel, quite possibly because of organized lobbying by medical groups.) That Japan surrendered soon after Germany increased the pressure for demobilization and undermined any military reason to keep troops in uniform. Four million men were demobilized in the second half of 1945, and over half the remainder were released in the first six months of 1946. But while demobilizing millions, the Army kept thousands of patients, and also hundreds of physicians and medical personnel as “critical” personnel; the decision that the VA was not able to care for the seriously wounded had ripple effects even after the fighting.

OTSG was granted authority to set the standards for discharging medical personnel, and promptly began looking at various specialties as well as broad numbers. After VJ Day, the few Medical Corps specialists with A, B, or C proficiency designators could be retained, and any specialist “essential to the proper care of patients” could also be held. This was apparently used especially for what would now be classed as specialists and sub-specialists: gastroenterology, ophthalmology, otorhinolaryngology, cardiology, dermatology, allergies, anesthesiology, neuropsychiatry, thoracic surgery, plastic surgery, orthopedic surgery, neurosurgery, and clinical laboratory work. The Surgeon General also laid down that no personnel would be discharged from a continuing position until there was someone available to relieve them. Even enlisted personnel (including orthopedic technicians) had their discharges over-ridden, albeit for only six months and they were promoted to lessen their anger.

Hospitals were closed as the declining patient population permitted. Station and Regional Hospitals were closed as the Army closed posts; RHs were downgraded as patient load permitted. GHs could not be closed so easily for two reasons. First, some patients needed lengthy care, especially amputees and plastic surgery cases. Second, demobilization health screenings brought in patients needing treatment, especially for TB and hearing impairment. Within the criteria for closing GHs, the specialized treatment center (e.g. for neurosurgery and amputees) were kept longer than other GHs. Convalescent Hospitals generally closed quickly; the Army no longer needed to ‘harden’ men for RTD and any after care could be their responsibility. The one exception was the convalescent hospital for the blind, still an Army hospital into 1947.

CHART 98



Army Service Forces Statistical Review, Statistics Branch, Control Division, HQ, ASF, War Department, [1945?], p.72.

NUMBER OF BEDS AUTHORIZED IN ZONE OF INTERIOR HOSPITALS

Year and Month	Total All Hospitals	General Hospitals	Convalescent Hospitals ^{a/}	Regional and Station Hospitals
<u>1941</u>				
December	74,269	15,533		58,736
<u>1942</u>				
January	94,341	15,831		78,510
February	102,361	15,882		86,479
March	105,387	15,538		89,849
April	107,300	15,709		91,591
May	108,396	16,281		92,115
June	116,971	16,219		100,752
July	128,602	16,517		112,085
August	113,211	15,223		97,988
September	121,594	16,352		105,242
October	138,226	18,571		119,655
November	147,845	22,471		125,374
December	175,801	26,004		149,797
<u>1943</u>				
January	200,078	31,321		168,757
February	209,508	35,642		173,866
March	228,893	38,096		190,797
April	241,732	40,731		201,001
May	259,189	46,591		212,598
June	276,237	54,828		221,409
July	285,506	62,721		222,785
August	299,843	65,408		234,435
September	335,630	76,217		259,413
October	345,909	79,685		266,224
November	354,315	82,333		271,982
December	357,154	84,028		273,126
<u>1944</u>				
January	364,539	99,785		264,754
February	381,701	101,471		280,230
March	381,552	107,279		274,273
April	370,416	112,244		258,172
May	368,247	110,543		257,704
June	303,674	103,921	t/ 13,122	186,631
July	294,586	110,754	17,229	166,603
August	295,082	114,406	20,515	160,161
September	279,617	114,139	23,970	141,508
October	279,096	114,313	26,630	138,153
November	282,559	119,459	30,535	132,565
December	269,531	119,459	31,591	118,481
<u>1945</u>				
January	298,219	152,699	27,650	117,870
February	318,105	153,327	43,075	121,703
March	317,240	153,362	50,075	113,803
April	324,463	153,595	56,076	114,792
May	335,631	163,197	60,551	111,883
June	343,141	163,995	62,978	116,168
July	341,757	164,364	61,356	116,037
August	327,986	162,924	57,806	107,256
TOTAL	-	-	-	-

^{a/} Includes beds in convalescent hospitals proper and in convalescent facilities when attached to General, Regional and Station Hospitals.

^{t/} Prior to June 1944 hospital facilities currently reporting separately as Convalescent Hospitals were included in either General or Regional and Station Hospital reports.

Army Service Forces Statistical Review, Statistics Branch, Control Division, HQ, ASF, War Department, [1945?], p.248.

At the beginning of 1947, the Army still had 35,000 GH beds, but only 16,000 SH beds. The imbalance towards specialty care showed that the Army was still treating non-RTD patients that it was unwilling to transfer to the VA.

Reconditioning and Rehabilitation

In 1943 the Army still believed the draft would provide unlimited high-quality manpower, and discharges from the Army averaged over 10,000 per month. Then suddenly the War Manpower Commission limited the Army's access to men, increasing the Army's interest in maximizing RTD numbers. There was also a push from physicians seeking to do the best for patients, and a few months before he became Surgeon General BG Kirk had been impressed with British reconditioning programs in Tunisia.¹⁶² Convalescent treatment was implemented, at first really reconditioning patients rather than rehabilitating. There was an effort made to keep that distinction, with the Army reconditioning and the VA rehabilitating. However, the VA's personnel problems undermined their ability to rehabilitate, and the same issue arose about rehabilitation in WWII as about OT in WWI: rehabilitation does not suddenly start, it helps in different forms throughout a patient's care, so the Army started rehabilitation programs.¹⁶³

In 1944 War Manpower Commission policies had not changed, and the Army was deeply interested in high RTD rates, so reconditioning of RTD patients not only continued, it expanded. In December 1944, for instance, Technical Bulletin Medical 122 laid down guidelines for physical therapy for amputees, even though they would not RTD. In 1945 TB MED 162 covered both convalescent care and rehabilitation of spinal cord patients, who would clearly not RTD but were still Army patients.

That these were Army programs is perhaps a fluke of history. Certainly the Army had a strong interest in reconditioning convalescents for RTD. However, physical medicine was in its infancy, with a tiny number of practitioners. Several happened to be in the Army; they might have been working for the VA, and the VA might have established an early reputation for rehabilitation. However, even in 1945 the VA had no effective physical rehabilitation program; the 18 doctors sent on the 1943 physical

¹⁶² N.T. Kirk, "Address," Archives of Physical Medicine (Oct. 1946), pp.636-638.

¹⁶³ See the short discussion in Organization and Administration, pp.213-4; F.H. Krusen MD, "Wartime Physical Rehabilitation" part I and II, Staff Meetings of the Mayo Clinic 8 and 22 September 1943; and the Kirk article mentioned above.

medicine course were no more than a drop in the bucket.¹⁶⁴ This would attract criticism from the doctors who pioneered physical rehabilitation, such as Howard Rusk. There had been no need for the VA to have a physical rehabilitation program. Only 400 paraplegic patients had survived to get to hospital in France; a third died there, another third died within six weeks of arriving in CONUS, and 90% of the remainder were dead within a year. Even if these numbers were too low and there were 50 surviving patients, it would have been hard for the VB to go beyond the state of the medical art. WWII would be different, and some 2,500 paraplegics survived. It was fortunate for those men that Rusk, Krusen, and physical medicine had advanced.

Psychiatric Patients

The Army started the war with only 35 physicians in psychiatric positions; of those only 20 had psychiatric training, and only 4 were board-certified.¹⁶⁵ Treatment, let alone definitive treatment, was going to be impossible for an expanded wartime Army. Training programs were established to expand the number of psychiatrists, first to accustom civilian psychiatrists to Army methods in a month, later 6- or 12-week courses to make ordinary physicians into semi-psychiatrists. Ultimately, 1,227 were trained, a tiny number for an Army that would peak at over 8 million men.¹⁶⁶

Long-standing Army policy was also to discharge psychiatric patients rather than provide lengthy hospitalization. AR 615-360 was categorical:

Individuals permanently unfit for Army service because of neuropsychiatric disturbances will not be retained for definitive treatment, but will be discharged and arrangements will be made for further care by the Veterans Administration if such is indicated.

This made some sense. There were no therapeutic drugs; first-generation anti-depressants (MAOIs) were not invented until the 1950s with tricyclic antidepressants following soon after. Cognitive/behavioral therapy was also pioneered in the 1950s. Army psychiatrists were not even authorized to use electroshock therapy until 1943, and then few hospitals

¹⁶⁴ This paragraph is largely based on A World To Care For: The Autobiography of Howard A Rusk, MD (New York: Random House, 1972), pp.58, 87-98, and “The Growth and Development of Rehabilitation Medicine,” editorial, Archives of Physical Medicine & Rehabilitation (Aug. 1969) pp.463-466. For a contemporaneous view, see “Physical Medicine is Employed to Rehabilitate Veterans,” Modern Hospital (May 1945), p.65.

¹⁶⁵ Neuropsychiatry: ZI, p.18

¹⁶⁶ Neuropsychiatry: ZI, pp.53-58.

had the equipment.¹⁶⁷ Lacking many treatment options, definitive care meant possibly life-long hospitalization, something that hardly suited the AMEDD mission. Even if treatment for a minor psychiatric problem seemed to cure a soldier, there could be no guarantee against a relapse. Without reliable treatment methods, it was hard to justify treating soldiers. More fundamentally, the regulation about not discharging soldiers until maximum benefit of hospitalization became fairly meaningless if hospitalization could not solve the problem, so the Army could both adhere to the regulation and discharge NP patients.

If psychotic soldiers were hard to treat, there were also problems discharging them. They had to go through a line-of-duty determination, a Sanity Board determination, and Certificate of Disability for Discharge (the equivalent of a MEB) determination; then there had to be a place to discharge them, i.e. legally responsible relatives or a recognized civilian mental hospital.¹⁶⁸ The steps meant the Army was holding patients on locked wards perhaps for several months, but treatment was still slight.

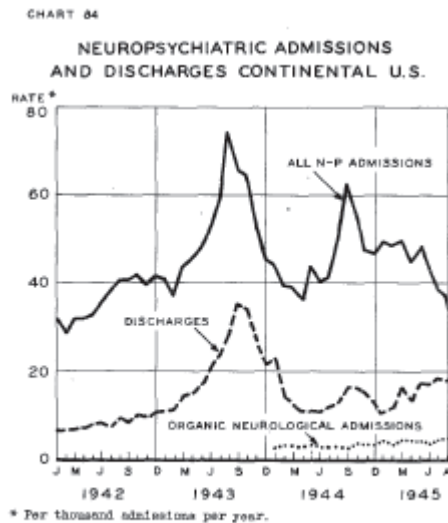
The problem category was psychoneurotic¹⁶⁹ soldiers. In modern parlance they might have an anxiety disorder, but in WWII the Army's concern was practical: the soldier was not much use. Even if not hospitalized, few neurotics were prime soldiers, and many commanders tried to use medical channels to rid themselves of marginal soldiers, "Sad Sacks," "goldbricks," or just the problem soldier who took too much of their time. Overlapping this, in what might be termed an administrative co-morbidity, was the Limited Service personnel category. LS personnel did not meet all of the physical standards, but were still worth inducting for some military service. Commanders had a natural preference for all their men to be good, not good-enough, and many commanders used both medical and administrative channels (AR 615-360 Section VIII or Section X) to purge LS men from their units. When the draft was bringing tens of thousands into the Army every month, and the nation's manpower pool seemed inexhaustible, there was

¹⁶⁷ *Neuropsychiatry: ZI*, pp.275-6.

¹⁶⁸ *Neuropsychiatry: ZI*, p.318.

¹⁶⁹ Almost all neuropsychiatric patients without neurological disorders or a psychosis were grouped under the umbrella term psychoneurotic. For instance, of the 389,159 soldiers discharged for neuropsychiatric problems, 52,200 were neurological patients, 62,062 psychotic, 2,653 had "disorders of intelligence", 3,163 "character and behavioral disorders", and 337 had "other" disorders. 69.5% – over 268,000 soldiers – were in the catchall "psychoneurosis" category. See *Neuropsychiatry: ZI*, p.204.

little incentive to keep marginal soldiers.¹⁷⁰ In 1943 the Army discharged over 105,000 soldiers for psychoneuroses plus another 54,000 men for inaptitude, unsuitability, or unfitness.¹⁷¹ Another 66,000 and 57,000 soldiers would be discharged in 1944 for the same reasons.



Army Service Forces Statistical Review, Statistics Branch, Control Division, HQ, ASF, War Department, [1945?], p.65.

However, when the War Manpower Commission told the Army there were limits to the numbers of men the Army could have, the Army began treating neurotic soldiers and retaining them, at least temporarily. On 1 April 1944, TB MED 28 opened:

The acute needs for manpower make it imperative that every treatment method available in station and general hospitals for neuropsychiatric patients be utilized to the maximum. The aim is to salvage every possible soldier for further duty. Those patients for whom there is no hope of salvage should be recommended for discharge. ... A high percentage of psychoneurotic patients can be salvaged, if treated, and the possibility of their salvage can be determined only by treatment. There is a tendency to misuse the diagnostic term "psychoneurosis." On the other hand, under sufficient stress of a specific type, any individual may develop a psychoneurotic disorder. Consequently, the presence of psychoneurotic symptoms may indicate an extremely difficult situation rather than a "weak" individual.¹⁷²

Within the AMEDD, the pressure seems to have been from the civilian psychiatrists now in uniform; they may have felt that the Army writing off individuals as poor soldiers and

¹⁷⁰ See *Neuropsychiatry: ZI*, pp.197-219, and this author's unpublished research on Limited Service personnel.

¹⁷¹ *Neuropsychiatry: ZI*, pp.204, 251.

¹⁷² While it is beyond the scope of this study, this seems to be part of a broader move in psychiatry to conceptualize all individuals as having limits rather than a breakdown indicating an inherent and irremediable flaw.

giving them psychiatric discharges was an abuse of psychiatry.¹⁷³ A test program from February-April 1944 had found that 70% of psychoneurotic soldiers could be reclaimed. However, they were only being reclaimed for Limited Service in CONUS – and the Army had a surplus of men for such assignment. The test program was not continued.¹⁷⁴ However, reconditioning of psychoneurotics was undertaken within the general program of reconditioning of convalescents, and produced unknown results.¹⁷⁵

Ironically, one successful NP rehabilitation program took place far forward. Combat exhaustion (what is now termed combat/operational stress) had generated substantial casualties in the Army's first major ground campaign, the 1942-43 operations in Tunisia. Evacuation to rear hospitals for treatment decreased the RTD rate and cost the Army effective soldiers. By re-learning the experience of WWI the Army rehabilitated soldiers for combat.¹⁷⁶

¹⁷³ Neuropsychiatry: ZI, pp.114, 198-99. The official history wistfully recorded the psychiatrists' view that it was better for the patients to recover their self-esteem rather than be discharged, but the Army's interest was in having effective soldiers. Ibid. pp.119-20.

¹⁷⁴ Neuropsychiatry: ZI, pp.114-120. Making rehabilitation somewhat more useful was a simultaneous end of the Limited Service category, replaced with the PULHES (Physical capacity/stamina, Upper extremities, Lower extremities, Hearing/ear, Eyes, Psychiatric) system that gave far more information about an individual soldiers' abilities and limitations instead of an either/or General Service/Limited Service categorization.

¹⁷⁵ TB MED 80, Reconditioning Program for Neuropsychiatric Patients. See Neuropsychiatry: ZI pp.687-694 for practical details of reconditioning psychiatric patients.

¹⁷⁶ William Mullins, ed., Medical Department, United States Army, Neuropsychiatry in World War II, vol. 2, Overseas Theaters, (Washington, DC: GPO, 1973) pp.989-1027 for a short summary. A fine longer study is Ben Shephard, A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century (Cambridge, MA: Harvard, 2001).

Chapter 4

1946-1956: A Changing Balance in Federal Healthcare:

Introduction

Neither the AMEDD nor the VA would be the same after WWII. Both substantially improved the quality of care, and after a variety of options for federal healthcare, Pres. Truman's decision was that the VA would handle chronic patients while the military focused on acute care. Implementation of this was subject to interpretation, and Surgeon General Raymond Bliss got into trouble for transferring as few patients as possible. His successor, MG George Armstrong, followed policy. Through the rest of this period, the AMEDD expressed no trouble with the policy, transferring patients but also retaining those who had a military future, even a limited one.

This period saw rapid developments in physical medicine and rehabilitation, and the public generally began to incorporate that into their expectations for the military. Skin grafts were available for burn patients, and physical therapy helped many walk who otherwise were limited to wheelchairs. Dr. Howard Rusk would have a column in the New York Times where he would discuss medicine but also influence public opinion about what could, and should, be done. The public expected the government to care for "crippled" veterans, and did not object when much care was provided through the VA.

The VA Readjusts To Peace

As the military demobilized from WWII, patients and medical personnel lagged behind. Pres. Truman made 'fixing' the VA a priority, and the Chief Medical Director, Paul Hawley (a retired Major General, Medical Corps) worked quickly, but it was still impossible for everything to happen at once.

Several things happened to improve the quality of VA medicine.¹⁷⁷ Gen. Omar Bradley, temporarily sorting out the VA as Administrator, made it a clear priority of his, acknowledging "the inadequate vehicle we had inherited" but saying he expected Hawley

¹⁷⁷ See, e.g., Paul Hawley, "The VA Sets its Sights for the best possible care in the most modern hospitals," Modern Hospital (May 1946) p.58 et seq.; "Hawley Insists on 'Medically Strategic' Placing of Hospitals," Modern Hospital (January 1946); "New Law Strengthens VA Medical Program, Hawley Declares," Modern Hospital (August 1946); "Bradley Revitalizes Medical Department of Veterans Administration," Modern Hospital (February 1946); Eli Ginzberg "Federal Hospitalization" Modern Hospital (April 1949) pp. 61-64, (August 1949) pp. 73-4, 124-30, (December 1949) pp. 43-47.

“to determine how first-rate medicine may be provided.” In late 1945 and early 1946 Bradley addressed the Disabled American Veterans and the American Legion, laying out his plans for improving medical care.¹⁷⁸

Hospitals were expected to cure patients, not warehouse them. To bring in more physicians, hospitals were built near population centers rather than in rural areas. Congress exempted the VA medical service from Civil Service pay scales and hiring rules; that not only allowed increased pay and made the work more attractive, the changed rules opened the way for another initiative. Hawley deliberately linked the VA with medical schools and teaching hospitals; physicians and surgeons could be part-timers for the VA, bringing expertise the VA did not need full time. This also deliberately overturned a Hines-era VA policy against medical students and interns in VA hospitals with veterans as “guinea pigs.” There were even hints that older VA physicians, out of touch with the changing practice of medicine, might be purged by committees of the new hires. And while this cannot be quantified, it was likely seen as patriotic for physicians to help the veterans by working for the VA.

By April 1946, the Association of Military Surgeons was already giving a vote of confidence to the VA’s plans and activities.¹⁷⁹ It recognizing substantial change: in FY1946 the VA went from 2,300 full-time physicians to 5,200 plus consultants and specialists and already had affiliations with 53 medical schools.¹⁸⁰ This allowed the VA to absorb 14,500 more patients, although there were still 12,500 in non-VA federal hospitals (6,075 in Army hospitals). In FY1947 the VA would get its training programs underway, gathering residents and interns who could help cope with the 18,000 more patients in 14 more hospitals.¹⁸¹ By 1947 the bulk of spinal-injury patients from WWII had been transferred to the VA, and the AMEDD had training accidents and dependents who were not eligible for VA care.¹⁸² In the remaining years before the Korean War, the VA would more gradually increase its numbers of patients and staff, but could focus on developing care. Psychiatric residents graduated, bolstering numbers and increasing the

¹⁷⁸ Collected Writings of Gen. Omar N. Bradley, vol.1, speeches 1945-49; 143, 14; speech 20 Oct 1945 to DAV, speech 27 Feb 1946 to National Rehabilitation Committee of the American Legion.

¹⁷⁹ Editorial: A Vote of Confidence, Military Surgeon (April 1946), p.343.

¹⁸⁰ ARVA 1946; P.B. Magnuson, “Where Do We Go From Here in Veterans Medicine,” Bulletin of the American College of Surgeons (January 1951) pp.45-47.

¹⁸¹ ARVA 1947.

¹⁸² AMSC, pp.558-9.

chances of helping patients; amputee care developed sharply (in collaboration with the Army Prosthetics Research Laboratory); and paraplegic care was developed.¹⁸³ By 1950, half the newly-boarded surgeons were trained by the VA, and the next year the Administrator testified to Congress that if the budget were restricted he would rather cut back the numbers of patients treated than compromise the quality of care.¹⁸⁴ The VA was also treating 25-30,000 Army patients per year, although this number includes Air Force patients from 1947 through 1949 when the Air Force separated from the Army.

The VA would also move quickly to offer physical rehabilitation programs, which were becoming increasingly standard in medicine.¹⁸⁵ On 20 July 1945 Bradley buttonholed Howard Rusk, a moving force in the Army's WWII rehabilitation program, saying "Rehabilitation will evidently be one of our biggest jobs. I don't know much about it, so I'll have to feel my way along."¹⁸⁶ Rusk became the organizer of the VA's rehabilitation program, and headed back to private practice, where he kept a high profile, both in medicine and the public through a newspaper column. His formulation of rehabilitation as the "third phase of medicine" showed it was now standard. By April 1947 it was possible to write lengthy articles about VA rehabilitation programs.¹⁸⁷ That year the number of physical and occupational therapists jumped from 102 and 115 to 532 and 432, in addition to the 55 new physical medicine doctors plus 20 consultants.¹⁸⁸

In the time it took the VA to build up, the Army had to care for veterans.¹⁸⁹ In late 1945 the Army held onto 100 physicians, ignoring their discharge eligibility, to care for patients. In mid-1946 there were more General and Convalescent Hospitals (34 and 6) than in late 1945 (20 and 3), although numbers would drop quickly in the second half of

¹⁸³ ARVAs 1948-1950. See also Eli Ginzberg and Herbert Klarman, "The Paraplegic," Bulletin of the U.S. Army Medical Department (October 1947), pp.892-97. It is not clear if any quadriplegics survived to need care.

¹⁸⁴ Magnuson, p.46. Many of these surgeons would of course have served in the military during the war. Statement, Carl R. Gray, Jr., to Senate Subcommittee Investigating Medical Care Policies and Practices of the Veterans Administration, 10 May 1951, p.2.

¹⁸⁵ "Modern Features Assured for VA Hospitals," Modern Hospital, October 1946.

¹⁸⁶ Rusk, World to Care For, p.95.

¹⁸⁷ A.B.C. Knudson, "The Medical Rehabilitation Program of the Veterans Administration," Military Surgeon, (April 1947), pp.323-329.

¹⁸⁸ ARVA 1947.

¹⁸⁹ See "Developments in Military Medicine during the administration of Surgeon General Norman T. Kirk," Bulletin of the Army Medical Department (June 1947), pp.520-562 and 594-646; "Army Issues Recall to 1000 Nurse Officers to Serve Army Patients," Modern Hospital (September 1946), "Army Releases Surplus Hospitals to Veterans Administration," Modern Hospital (July 1946); and Maj. Gen. Norman Kirk, "The Remaining Task," IAMA (6 April 1946), pp.918-921.

1946 to 14 and 1. Demobilization also proved temporary for some AMEDD personnel, as in September 1946 1000 nurses were recalled to care for remaining patients, with other AMEDD officer groups in proportion.

The AMEDD Amid Change

As the VA adapted to a larger, but defined, patient population, the AMEDD was facing a world of few certainties except radical change.

To recruit and retain physicians, in 1946 the Army established a graduate medical education program. It started with fifteen residency programs in nine general hospitals. While it would take years to pay off in either numbers or quality, the Army lacked a draft or high pay to offer physicians, and needed to offer something. (The residency program would also gradually address a problem MG Kirk had seen in the Medical Corps of the Regular Army. Physicians were generalists and administrators instead of highly skilled clinicians, and sometimes were professionally disdained by the wartime physicians who were more specialized.) In the meantime there were still patients to be seen. The patient population ebbed and flowed; demobilization dropped the number dramatically, but the 1940 embargo on dependents lapsed (exactly when is unclear) so wives and children were again in the patient population.

The decision for GME also led to some counter-intuitive moves. Amid a shortage of physicians, the AMEDD still agreed to offer the VA several thousands beds in order to broaden the range of patients and problems seen, and thus support GME.¹⁹⁰ The Surgical Research Unit (now the Institute of Surgical Research) was also created in 1946; by 1949 it was focused on burn patients and was taking clinically-interesting patients, military or civilian.¹⁹¹

Another move by TSG in late 1946 was creating Physical Medicine Services in all the large (over 750 bed) General and Station Hospitals. This followed the April 1946 appointment of a Physical Medicine Consultant, formal recognition in the Army and an

¹⁹⁰ Memorandum for the Secretary of War, Request of Veterans Administration for Beds in Army Hospitals, 31 January 1946, Tracy S. Voorhees Papers. It also allowed the Army to keep one doctor on active duty per 30 VA patients, and the VA paid for them. Voorhees, "Lawyer Among Army Doctors."

¹⁹¹ AMSC, p.554.

institutional anchor that continues to this day.¹⁹² The Consultant oversaw medical activities, while educational and other activities were under the Convalescent Services Branch of the Hospital Division of OTSG.¹⁹³ Along with a formal physical medicine program, the Army Prosthetics Research Laboratory was created at Walter Reed General Hospital in August 1945, pulling together several R&D elements and also intended as a continuing research organization.¹⁹⁴ Yet recognition did not mean large size; the demobilization meant that in June 1946 there were only six physiatrists in the Army.¹⁹⁵

The AMEDD itself saw some changes. In 1947 nurses were made a Regular Army corps; the Medical Service Corps was created out of the Pharmacy Corps, the Sanitary Corps and the Medical Administrative Corps; and the Women's Medical Specialist Corps was created for OTs, PTs, and dietitians. In 1947 the U.S. Air Force was created, although for two more years the Army provided medical support. Also in 1947 the National Military Establishment was created, a step towards the Department of Defense. In contrast to independence for the Air Force, there was consideration at the time of unifying the armed services, and also to separately unifying the medical services. On 25 March 1947 the Chief of Staff of the Army (GEN Dwight Eisenhower) testified on the possibilities of unifying the medical services and also on merging the VA and Army health systems.¹⁹⁶ That would fizzle out, but there would be more inter-service cooperation. All this was quite fresh when MG Raymond Bliss became The Surgeon General on 1 June 1947; Bliss would have to operate amid an unusually fast pace of change in the military. The Armed Services Medical Regulating Office would be established on October 25, 1950; the Office of Medical Services would be established under the Secretary of Defense in May 1949, to coordinate military healthcare, and would eventually become the Assistant Secretary of Defense for Health Affairs.

¹⁹² "Physical Medicine and Reconditioning," Bulletin of the U.S. Army Medical Department, (October 1946) pp.399-401.

¹⁹³ Mastellone, "Physical Medicine in the Army: History and Development."

¹⁹⁴ Zobelein, 11; Memorandum for the Secretary of War, Report as to Research Program for Artificial Limbs, 17 July 1946, Tracy S. Voorhees papers.

¹⁹⁵ Mastellone, "Physical Medicine in the Army: History and Development." LTC Benjamin A. Strickland, Jr. was apparently the consultant. His article "Physical Medicine in the Army," (Archives of Physical Medicine, April 1947, pp.229-36) is thoroughly optimistic.

¹⁹⁶ Cited in Cowdrey, Medics' War, 23.

In 1948 the draft would resume; for the AMEDD it created more work, as draftees not only got healthcare, they also required physicals to determine their eligibility for the Army. Meanwhile, the draft did not extend to doctors and few volunteered, leaving the AMEDD further overburdened. A smaller problem for the Army was psychiatric patients; in 1948 St. Elizabeths stopped taking prisoners, and the VA could not, so the Army had to put them in a prison ward of a hospital unless their home state would take them.¹⁹⁷ In mid-1948 Surgeon General Bliss was also getting pressure from the Assistant Secretary of the Army, Tracy Voorhees (a lawyer who had worked in the AMEDD in WWII sorting out supply and administrative problems) to use the VA more. Bliss' initial reaction was that the interwar VA had been poor and that only 15-20% of VA hospitals were now good enough. Voorhees continued his pressure, thinking the Army could use 3-4,000 beds in VA hospitals as well as sending long-term patients (his example was TB patients), and urged that while the Army should get VA patients for GME purposes they should not stay too long.¹⁹⁸ (The Surgeon General had a daily meeting with his senior staff, and the minutes for 1947-69 are preserved in the National Archives.¹⁹⁹) Another possible source of patients was atomic warfare. While the US had a monopoly on atomic warheads until 1949, it was clear the Soviet Union would develop them, and some planning for civil defense began.²⁰⁰

There were a number of task forces examining both the structure of the federal government and daily operations. The Hoover Commission began its work in 1947; it would make recommendations to the President in 1949. It recommended a National Bureau of Health, taking over all VA medical facilities, the PHS, St. Elizabeths, all the military general hospitals (save one per service), and all station hospitals that were not geographically remote. Secretary of the Army Kenneth Royall sent for Surgeon General Bliss on the afternoon of 5 January 1949. Bliss immediately protested the

¹⁹⁷ AR Secretary of the Army, 1948, 271-2.

¹⁹⁸ SGMC 2 Aug 1948, 22 Sep 1948, 27 Oct 1948.

¹⁹⁹ RG 112, entry 1019, boxes 1-11. The meetings were not exactly daily, and became weekly at the end. At times papers under discussion at the meetings are included. These will be cited as SGMC (Surgeon General's Morning Conference) with the date. Supporting papers included in the volumes will be cited the same way.

²⁰⁰ See, for example, Col. William Wilson, "Civil Organization for Health in Time of War," Bulletin of the U.S. Army Medical Department, (October 1948), pp.778-789 and Brig. Gen. George Armstrong, "Medical Cooperation in Civil Defense," Military Surgeon (May 1948), pp.335-338.

recommendations, and Royall directed Bliss to say nothing about the report publicly or privately; Bliss wrote a Memorandum for Record, and proceeded to ignore the Secretary's order and politicked against the report. On 21 February the Chief of Staff of the Army sent Bliss a note reminding him to be quiet, but ultimately the Hoover Commission report would be tabled.²⁰¹

A second task force was the Committee on Medical and Hospital Services of the Armed Forces, headed by Paul Hawley. It focused on overlapping facilities, for instance the number of military hospitals around New York City. Recommendations to consolidate patient care would save medical personnel across the services and seem to have been easily agreed, partly because by showing savings the medical departments improved their position in asking for a doctor draft. (The AMA opposed such a draft until August 1950, when, with a war on, it was unequivocally proven that sufficient physicians would not volunteer to fill the medical departments.²⁰²) The committee also recommended

the earliest possible appropriate disposition of those military patients in whose cases it has been determined that because of physical incapacity or mental disorder their restoration to active military duty is not possible

to the VA.²⁰³ It recognized that existing legislation was complex and would cover a dwindling number of patients since post-1945 veterans were ineligible for the VA, but its intent was clear.

A third group mulling the military health system was an in-house group. In February 1949 the Joint Chiefs of Staff proposed to the Secretary of Defense a study about unification. An Armed Forces Medical Advisory Committee was appointed with civilian experts and the Surgeons General. Unlike many government committees, they reported expeditiously. In May 1949 they suggested a central coordinating office in the Pentagon rather than unification of the medical departments.²⁰⁴

²⁰¹ Copies on file, Office of Medical History.

²⁰² Even in July the AMA protested a draft, saying that as long as the AMEDD was doing anything beyond RTD of patients there was no need for a draft. The AMA was thus aligning itself with an AMEDD mission to "conserve the fighting strength" and not care for either the non-fighting strength or dependents. SGMC 26 Jul 1950.

²⁰³ Committee on Medical and Hospital Services of the Armed Forces, report pp.6-8, copy on file Office of Medical History.

²⁰⁴ Meiling, "Medical Care for Members of the Armed Services," p.94.

With task forces investigating, and GEN Eisenhower mulling unification with the VA or the other military services, it is little wonder that Bliss was hesitant in November 1947 to say much about coordination and even unification of the military health services, the PHS, and the VA.²⁰⁵ In a wide-ranging memo a month after becoming Surgeon General, Bliss had mused about relations with the VA. He wanted some VA patients to help Army GME programs and also to bring VA consultants into Army hospitals. By September his thoughts had progressed: the Army should take VA patients to build workload and justify funds for new hospitals. VA patients would still round out residency programs, but the VA could take Army patients too.

Would we consider sending Army patients to Veterans Administration hospitals in certain locations or for certain specialized work? If not, why not? Where would we consider this?²⁰⁶

In December, when the question arose of transferring Army & Navy General Hospital (mainly used for arthritis patients) to the VA and reserving some bed space for military patients, Bliss thought aloud in his morning conference:

Gen. Bliss said the whole thing hinged on the question of whether or not we were willing to accept VA hospital treatment or not. He said in the past we had not done it because they were not up to standard but he did not feel that it was true now.²⁰⁷

In 1948 Bliss would grow more comfortable with using the VA. In a national emergency the VA had agreed to end non-service-connected treatment and set aside 30,000 beds for the Army. Bliss thought, "It might be well in the event of an emergency to have the VA become to the Army what the Coast Guard is to the Navy."²⁰⁸ However, he qualified that, and thought the VA should hand over hospitals in wartime rather than hospitalizing Army patients.²⁰⁹ But Bliss knew the administrative problems: dependents were not eligible for care and would require new legislation, there was already a backlog of non-service-connected patients for the VA, so the veterans' organizations would fiercely fight new legislation that put Army dependents ahead of veterans care.²¹⁰

²⁰⁵ Raymond Bliss, "The Army Medical Department Faces the Future", Bulletin of the U.S. Army Medical Department, (January 1948), pp.31-37.

²⁰⁶ "Thoughts on the Overall Aims of the Current Medical Administration," 1 July 1947; "Thoughts on Implementation," 8 September 1947.

²⁰⁷ SGMC 22 Dec 1947.

²⁰⁸ SGMC 30 Mar 1948.

²⁰⁹ SGMC 12 Oct 1948.

²¹⁰ SGMC 23 Jul 1948.

Cutting Back Access To Army Hospitals

Using the VA was a possibility, but in 1949 the Army faced a dire shortage of physicians. Something else had to be done, and on 1 March the Secretary of Defense wrote the Service Secretaries directing steps be taken to reduce medical workload.²¹¹ Beyond that, the military considered recommendations from some high-powered advisory committees that had been established. For instance, on 20 March 1949 Dr. Edward Churchill (professor of surgery at Harvard and chief of surgery at Massachusetts General Hospital, Brigadier General in WWII) offered seven proposals to reduce workload starting with reducing care for dependents. He also recommended “elimination of highly specialized or long term treatment for diseases with low return to duty expectancy.”²¹² Army hospitals stopped taking VA patients except for GME purposes.²¹³ But the military had to do more and on 16 June 1949 the Army issued Special Regulation 40-10-5. After reviewing the impending dire shortage of physicians (due to WWII trainee physicians finishing their obligation before the first Army-trained residents were ready), strict measures had to be taken. Some were administrative, such as issuing CDD to outpatients instead of requiring them to be admitted as inpatients first.²¹⁴

More important was the section on Expeditious Disposition of Patients:

The term “maximum hospital improvement” is subject to wide interpretation. It is defined as the time when the progress of the patient appears to have leveled off and no further substantial improvement can be anticipated. Many patients will continue to improve slowly over a long period without specific therapy or medical supervision. These patients should be considered as having reached maximum hospital improvement for disposition purposes. Many patients, especially those who have had a prolonged period of hospitalization, reach a stage where further hospitalization is unnecessary. These patients usually have not made compensatory physical or psychological adjustments, which are largely a matter of time. It is not necessary to retain such patients in hospitals until they have made all the adjustments required...

While the regulation was wordy, the intent was clear: hospitals should discharge patients sooner rather than later.

²¹¹ This directive has not been located, but two separate memos refer to it.

²¹² Personal Statement of Dr. Churchill at the meeting of the Armed Forces Medical Advisory Committee, on file, OMH. Churchill wanted to stop taking VA patients in military hospitals, but the full AFMAC watered down that recommendation; VA patients would be accepted up to GME needs and where there was indeed space. Memo to SecDef, Subj: Reduction in the Allocation of Beds for Veterans in Military Hospitals, 8 April 1949, on file OMH. On 23 April, the Secretary of Defense would send such a memo to the Administrator of Veterans Affairs. Letter, on file OMH.

²¹³ SGM 4 Apr 1949.

²¹⁴ Reports on declining times for PEB decisions (as low as 46.7 days) are in Health of the Army, August 1952, pp.12-17 and September 1952, pp.4-8.

There were other meetings between the Army and the VA. By June 1949 there were talks about what the VA could do to help in a mobilization or national emergency.²¹⁵ There were still administrative problems in putting military patients in non-military hospitals, and the solution was to use the VA for only non-RTD patients who would spend more than six months hospitalized.²¹⁶ By June 1950 the VA would vaguely report principles of a framework for conjunction, so these talks were slow and unproductive.²¹⁷

The Career Compensation Act of 1949²¹⁸

The first major overhaul of military pays and allowances since 1922, the CCA added allowances (such as Basic Allowance for Subsistence), hazardous duty pays, and proficiency pays. Intended to provide equitable treatment for military personnel (partly by equalizing pays across the military services; which had been set separately, allowing services to cannibalize personnel from each other through higher pay), it also had to deal with a need for a large and long-term military, whereas previously the U.S. had either a large military or a long-term one.

One provision in the CCA was the Temporary Disability Retirement List. The TDRL recognized the interest of would-be career military personnel (who would want to recover and return to active duty) and the growing complexity of medicine (which might be able to return patients to duty after extended periods). Personnel could be temporarily retired for up to five years, subject to periodic physical examinations to see if they were again fit for duty. While nothing specific has been found, it seems unlikely that non-careerists would avail themselves of the TDRL, not from a monetary standpoint but because it implied they wanted to wait around and complete their military service. The TDRL gave personnel time to recover, but also got them out of hospitals – something the AMEDD presumably appreciated.

A second relevant provision was section 414(b). Based on that section, in April 1950 Pres. Truman issued Executive Order 10122.²¹⁹ This directed that as of 1 October

²¹⁵ Mentioned in Minutes, 15th Meeting, Hawley Committee, on file OMH.

²¹⁶ SGM 7 Oct 1949. Surgeon General Bliss also wanted to know what the WWII experience was to learn from history.

²¹⁷ ARVA 1950.

²¹⁸ For lengthy coverage of military compensation and related matters, see Military Compensation Background Papers, sixth edition DOD, USD(P&R), 2005.

chronic patients, and those judged not likely to return to duty, became a VA responsibility.²²⁰ Truman would slightly modify it in 1952 (E.O.10400), to actually send more patients from military hospitals to the VA. (There were few implementing regulations or directives for two years, perhaps because the Korean War intervened.) For awhile all E.O.10122 amounted to was putting different interpretation on the existing regulations about discharging patients and “maximum benefit of hospitalization.” The VA seems to have had no problem with this policy. When Truman appointed a high-powered committee to study VA medical services in June 1950, their report urged transfer of all non-RTD patients to the VA as soon as possible.²²¹ That point was in their summary, and they felt it was strong enough, and obvious enough, that they did not revisit it in their detailed explanations. On 9 February 1951 the Secretary of Defense would direct the military departments to follow the committee’s recommendations; the results of this for the Army are discussed below.²²²

For a military health system focused on caring for military personnel, with dependents only on a space-available basis, the VA was a strong option. The patient populations were essentially identical (even for non-service-connected medical conditions) and the much-larger VA medical system could take a substantial load off the military – especially of patients with little value to the military since they were non-RTD and/or chronic. The ASD(HA), Dr. Richard Meiling,²²³ summed it up:

The basic reason for the existence of the military medical services is to provide support for the men who fight. Other activities, in peace and in war, frequently compete for time, talent, and funds; but anything that deflects the medical services from this supporting mission is a liability against the military strength of the Nation.²²⁴

The Korean War

In the first half of 1950, the DoD was under severe financial constraints. In a cost-cutting move, eighteen military hospitals were to be closed or transferred to the VA, intended to

²¹⁹ Drafts had circulated from November 1949 through March 1950. See SGMC for the period.

²²⁰ Chronic diseases included “chronic arthritis, malignancy, psychiatric or neuropsychiatric disorder, paraplegia, tuberculosis, and such other diseases as may be so defined jointly by the Secretary of Defense, the Administrator of Veterans’ Affairs, and the Federal Security Administrator...” The Federal Security Administration was the predecessor of health part of the Department of Health and Human Services.

²²¹ Report to the President from The Committee on Veterans’ Medical Services, 22 September 1950, GPO.

²²² Health of the Army, 1954, volume II, report II, p.2.

²²³ Technically, Meiling was Director of Medical Services, but the position has become ASD(HA). He was also a major general in the USAF Reserve.

²²⁴ Richard L. Meiling, “Medical Care for Members of the Armed Services,” Annals of the American Academy of Political and Social Science, (Jan 1951), pp.93-98.

save \$25 million per annum.²²⁵ For the Army, this meant the closure of four general hospitals and bed reductions as most others; the total reduction was 5,465 beds or 35% of GH capacity.²²⁶

The practice of medicine had advanced from the end of WWII. Penicillin was widely available. Helicopters would evacuate many casualties to hospitals. Respirators were available in hospitals. Dialysis through artificial kidneys would help renal patients.²²⁷ Away from the battlefield, recovery wards improved patient outcomes after surgery. The advancing practice of medicine meant not only more wounded would survive, but more seriously wounded patients would survive. This would potentially increase the duration of patient stay, as those with more significant injuries would need lengthy recovery.

Immediately after the fighting began, the AMEDD was swamped with casualties. With the GH system truncated, there were many problems accommodating the wounded. Two weeks after American troops entered battle the ASD(HA) recommended sending patients to the VA to create space for the wounded. The ASD(HA) also brought the VA and PHS into his Military Medical Advisory Committee, giving them equal voice with the service Surgeons General.²²⁸ Two weeks after that the Deputy Surgeon General agreed that non-RTD patients should get only “acute phase” care in military hospitals, although he put no time limit on that.²²⁹ Bliss was resistant to using the VA, although he also did not want to open an Army blind rehabilitation center.²³⁰ There were discussions in August (as fighting raged around Pusan, before the Inchon landing and invasion of North Korea) about work with the VA, but there is no record of formal arrangements.²³¹ Given the apparent collapse of North Korea heralding an end to the fighting, it may have looked like nothing further was needed.

²²⁵ “18 Military Hospitals to Be Closed or Transferred,” Modern Hospital, (April 1950)

²²⁶ Semi-annual report, Resource Analysis Division, SGO, 1 August 1950, on file OMH.

²²⁷ As an example of the advancing practice of medicine, see Battle Casualties in Korea: Studies of the Surgical Research Team 4 vols. Army Medical Service Graduate School, 1952-56.

²²⁸ Meiling, “Medical Care for Members of the Armed Services,” p.95.

²²⁹ SGMC 17 Jul and 31 Jul 1950.

²³⁰ SGMC 19 Jul 1950. These minutes are confused; Bliss did not want to use the VA, but later referred to using the VA in exchange for not calling up reservists working for the VA. However, the Army mobilized VA reservists and used VA hospitals.

²³¹ SGMC 9 Aug, 14 Aug and 23 Aug 1950.

The ASMRO responded appropriately by sending Army patients to Navy hospitals: on 31 October 1950 there were 2,300 WIA soldiers in CONUS Navy hospitals and 2,700 in CONUS Army hospitals, but for a time the Army actually had more casualties out to non-Army hospitals than in CONUS General Hospitals. The Army mobilized reservists, brought three GH out of mothballs (including some that had been closed on 30 June at the end of the fiscal year), and expanded and reactivated station hospitals (some of which were upgraded for specialized treatment).²³² With a sudden need for physicians, the AMA withdrew its opposition to a doctor draft, and Public Law 81-779 sailed through the Congress. The Army would get the doctors it needed, although it would take several months for Selective Service to process them.

During the summer crisis the DoD issued three directives on 4 August 1950.²³³ First, policy was to hospitalize military patients in military hospitals until it was no longer reasonable to expect RTD; a specific provision was made for specialized rehabilitation and resocialization at non-military hospitals (i.e. the VA) for “long term and chronic military patients as appropriate and as directed by the Secretary of Defense.” The second directive both suspended admission of VA patients into military hospitals, but balanced that with a delay in calling up reservists that worked for the VA. The third froze any thoughts of the military taking back over hospitals that had been transferred to the VA; instead policies on care would be agreed between the VA and DoD.

The first year of fighting would see the bulk of battle casualties, and at the end of August 1951 the AMEDD was up to 26 GH (28,000 beds); as the fighting dwindled this was trimmed to 24 GH (25,000 beds) at the end of January 1953, and to about 11,000 by the end of December 1953.²³⁴ Eventually 19,465 Army wounded would be evacuated to CONUS, against 33,148 non-battle cases.²³⁵ Late in the war patient numbers were low

²³² “History of Department of the Army Activities Relating to the Korean Conflict,” 5 November 1951. CMH file 40-1.1 AA 1950-51. See also Cowdrey, *Medics’ War*, p.293.

²³³ No number for these has been seen, and thus the originals have not yet been tracked down. This paper relies on the one-paragraph summaries of each provided in the original report. Titles were “Hospitalization Policy of the Department of Defense,” “Veterans Administration Medical Services in Relation to Department of Defense,” and “Mobilization Plans – Use of Veterans Administration Facilities”.

²³⁴ “History of Department of the Army Activities Relating to the Korean Conflict.” CMH file 40-1.1 AA 1951-52; ARSG CY1953, number approximate as it is interpreted from chart on p.75. It is not clear how much of the increase was more hospitals and how much expanding existing hospitals.

²³⁵ Frank Reister, *Battle Casualties and Medical Statistics: US Army Experience in the Korean War*. Washington, DC: GPO, 1973.

enough, and the hospital system large enough, that even the POW exchanges caused no major problems. For instance, during calendar 1953, only 2,500 of the 22,500 personnel discharged for disability were combat-related.²³⁶

Problems in the Army-VA relationship would start developing in the winter of 1950-51. The first patients transferred from the Army were blind or paralyzed. The Blinded Veterans Association protested the quality of military care for the blind and wanted early transfer to the VA; the National Paraplegic Foundation thought the VA was lagging the military and either wanted the VA improved or an end to transfers. The Army “has no intention” of setting up blind or paraplegic centers, but did not want patients transferred to the VA before PEBs were completed; to expedite VA processing, VA personnel were invited to come into Army hospitals.²³⁷ The next moves were the most convoluted. Carl Gray, Administrator of the VA, persuaded Pres. Truman that the military should send more patients to the VA; Truman deputed Howard Rusk to make it happen, and Rusk met with the ASDHA and representatives of the three services (the Army sent the Deputy Surgeon General) plus the VA. That meeting was on 18 January 1951, and the agreement was that all patients not expected to RTD would be sent to the VA for care; if they did recover sufficiently, they could RTD. There was a substantial list of specific conditions, and a proviso that the Army and Navy could continue their amputee centers for research and “less severe” amputees who might RTD. After reading Rusk’s report, Surgeon General Bliss exploded. In his senior staff meeting, with Deputy Surgeon General George Armstrong present, he “did not approve of the letter and said he doubted whether anyone attending the meeting in Dr. Rusk’s office had ever been in a VA hospital and, therefore, none of these individuals knew whether the VA had the proper facilities to take care of chronic cases.” Bliss may have been thinking that the VA was seeking to squeeze out non-service-connected patients (who only had space-available status) or he may have been remembering the prospects of defense medical unification that had been suggested in the 1949 Hoover Report. Regardless, it was fairly clear he

²³⁶ ARSG, 1953. Within the 22,500, 7,500 were retired for disability; 5,000 of those were permanent retirements and 2,500 were using the new TDRL.

²³⁷ SGM 13 Dec 1950, 9 and 11 and 16 Jan 1951.

wanted the Army to deliberately abuse the clause saying that each case would be reviewed on an individual basis to avoid transferring patients.²³⁸

On 20 March 1951 Bliss' deliberate inaction was caught. Dr. Richard Meiling, the ASD(HA), personally called the ASMRO; the VA knew there were 295 military patients identified for transfer to the VA, including some blind patients that were not getting training that the VA could provide. The VA had threatened to pass word to Pres. Truman that the military was dragging their feet. The duty officer could only cite "administrative procedures" as an excuse, but Meiling responded that paperwork could be sorted out later or Pres. Truman would be upset. Truman's known temper cut through the paperwork. Two days later the Adjutant General had a message going out titled "Early Transfer To The Veterans Administration Of Those Army Patients Whose Disabilities Make Improbable Their Return To Active Duty" that specified immediate and continuous screening of patients. Four days later those "administrative procedures" were being sorted out: patients would generally be transferred after a PEB but not always; for administrative and disciplinary purposes the Army would also set up Technical Services Units at VA hospitals (at least those more than 50 miles from Army hospitals and having 40 or more Army patients).²³⁹ Nine days later, still under suspicion, the Army said the number actually transferred was not a fair count because many were in process – and then tried to point the finger at the Navy, which (it was claimed) had transferred no patients and did not intend to. Three weeks later Meiling was again threatening Truman's wrath: the January agreement had never said that PEBs had to precede transfer or that patients had to be rated 80% or more disabled. Meiling hinted he recognized these as stalling tactics and that he would not protect the Army if they continued.²⁴⁰

Seven weeks later, on 13 June 1951, TSG was now concerned about the number of patients that had not been transferred. On 31 May 1951 Surgeon General Bliss retired, and DSG George Armstrong (who had attended the January meeting and agreed the policy) was promoted. Armstrong said he was concerned about triple and quadruple amputees – hardly candidates for RTD – who were still at Walter Reed. The commander

²³⁸ SGMC 16 and 18 and 29 Jan 1951. A byproduct was a backlog of 50 amputees at Walter Reed, waiting for final prosthesis. Patients would be offered transfer to the VA if they wanted. SGMC 2 Mar 1951.

²³⁹ SGMC 20 Mar, 22 Mar, 26 Mar 1951. Quite obviously these were the Korean War equivalent of Warrior Transition Units.

²⁴⁰ SGMC 4 Apr, 24 Apr 1951.

of Letterman General Hospital (BG Leonard Heaton, who would take command of Walter Reed and then be Surgeon General 1959-69) arrived with mixed comments: he was transferring both amputees and the blind to the VA, but there was a grapevine among amputees that Army care was preferable. Armstrong did not comment then, but his actions through 1951 showed he was a strong proponent of transferring patients. In August and November he wrote hospital commanders reminding them to transfer “non-salvageable” patients to the VA. The slackening pace of fighting led to an unusual concern in mid-1952, that the services would prolong care on patients and not transfer them to the VA. (An isolated datum was that 15% of Walter Reed’s amputees had RTD in calendar year 1951.) Armstrong seems to have kept this in check, and there was little further discussion. The last mention at TSG’s morning conference was just an anecdote, that a double-amputee had been 14 months at Letterman and should go to the VA. The apparent reason he had not was his Army pay was \$117/month higher than his disability allowance would be.²⁴¹

Convalescent Care

Substantial efforts were made to return convalescents to duty in theater, with both OTs and PTs involuntarily recalled to provide staff.²⁴² They treated convalescent patients in Japan, and apparently also in some rear-area hospitals in Korea.²⁴³ Convalescent centers in Japan boosted RTD rates and shortened hospitalization. Even without performing rehabilitation work in theater, reconditioning was now part of the standard of care; moreover, it was advisable to recondition patients rather than prematurely return them to duty, have to have them return to the hospital, with their breakdown not only a medical problem but a potential public embarrassment. However, the theater evacuation policy differentiated between reparative surgery and reconstructive surgery. It was semantics,

²⁴¹ SGM 13 Jun, 27 Aug, 7 Nov 1951; 22 May 1952; 24 Apr 1953.

²⁴² AMSC, pp.374-5, 377-8. Reconditioning programs were apparently run by Medical Service Corps officers, while physiatrists ran rehabilitation programs. Mastellone, “Physical Medicine in the Army: History and Development.”

²⁴³ Cowdrey, Medics’ War p.255. Some hospitals in the Korean Communications Zone functioned as Level IV hospitals.

but ‘reconstructive’ was essentially used to mean patients that would not RTD in theater. It presumably led to decisions on what staff to send to Japan.²⁴⁴

It took almost two years before the Army had time to write E.O.10122 into regulations as AR 40-680, Length of Hospitalization and Disposition of Patients. It repeatedly took a firm line:

An Army patient on extended active duty who is considered likely to be permanently medically unfit ... will be evaluated with a view toward disability separation ... as early as the permanency and degree of his disability can be sufficiently ascertained...

Patients ... will be considered by a medical board or referred to a physical evaluation board when they attain optimum hospital improvement for disposition purposes, or 6 months after their date of initial admission to hospital, whichever comes first. ...

Within this category, particular attention should be given to the timely processing for disability separation and transfer to Veterans Administration facilities of those patients who are *permanently* medically unfit as a result of a disability which is *permanently* rateable at 75 percent or more in accordance with Veterans Administration standards ... Ordinarily such patients can and should be processed for disability separation and transfer to Veterans Administration facilities as soon as they become transportable. ...

In the great majority of these doubtful cases the patient’s prospective fitness for further active service ... can be determined within 6 to 12 months following the date of his initial admission to hospital. In the event that a decision ... has not been reached within 18 months following his date of initial admission to hospital, the patient will be considered by a medical board with a view toward final disposition. ...

It is not within the mission of the Army Medical Service to provide definitive medical care to those patients requiring prolonged hospitalization who are unlikely to return to duty. Ordinarily such patients should be processed for disability separation when they achieve optimum hospital improvement for disposition purposes,²⁴⁵ and arrangements made for their continued care through Veterans Administration or other appropriate nonmilitary medical treatment facilities as early as the patient’s permanent retirement or separation is reasonably assured.

The Army was certainly going to treat its patients, but it was not going to hold them long. The six-month deadline for boarding and the eighteen-month deadline for final disposition indicated the AMEDD’s primary purpose was “conserving the fighting strength” and not caring for those who could not fight. Those patients were a government responsibility, and were cared for by the government, but through the VA.

²⁴⁴ See Recent Advances in Medicine and Surgery, Vol. I (Army Medical Service Graduate School, Walter Reed Army Medical Center), 1954 for more on reparative surgery, physical medicine, recovery rates, and transfers to the VA.

²⁴⁵ AR 40-680 included a definition of this phrase: “that point during hospitalization when, following the administration of *essential initial* [original emphasis] medical treatment, the patient’s medical fitness ... can be determined, and it is considered probable that further treatment for a reasonable period will not result in any change ... which will alter his ultimate form of disposition... Generally ‘optimum hospital improvement for disposition purposes’ will be achieved prior to the time that ‘maximum hospital benefit’ has been attained...”

With the VA in charge of long-term patients, there were problems getting enough rehabilitation patients for OTs and PTs, and that affected retention rates.²⁴⁶ Since the Executive Order was not changed until 1973, several presidents did not see this as particularly significant.

For the VA, the Korean War had moderate impact, at least judging by the lack of problems described in annual reports.²⁴⁷ Congress granted Korean-era servicemembers access to the VA; previously most post-WWII veterans were ineligible. That increased the beneficiary population, but not substantially compared with the huge number of WWII veterans. In 1950-51 the VA lost 547 doctors, 70 dentists, and 605 nurses to the armed forces, but was able to cope. The Armed Forces readily transferred non-RTD patients to the VA; paralytics and the blind were transferred from 1950 onwards. (In WWII the military had held the blind, but in 1950 a DoD agreement noted the quality of VA care and felt it was in the best interest of the patients to have continuity of care through the VA. In 1954 the VA was performing corneal transplants.) On 1 July 1951 the VA created a separate coordinator for paraplegic affairs, continuing its focus on their care. The VA also cared for some active-duty personnel; statistics are imprecise, but some 800 active-duty personnel were in VA hospitals on the snapshot date of 31 January 1953, although some of these would be spinal-cord injuries, blind, etc. The number of rehabilitation beds would climb to nearly 2,000 during this period.

Aftermath of Korea

The end of the Korean War created no great dislocation for either the AMEDD or the VA.²⁴⁸ Congress continued to fund a moderate expansion of the VA, which took care of a modest number (500-800) active-duty patients per year. The VA operated substantial prosthetics facilities and greatly expanded its physical rehabilitation capabilities, trying to cure patients, which would have the further benefit of reducing costs.²⁴⁹ The military also sent some 1,500 TB patients to the VA annually; apparently they were discharged from the military but treated in the VA rather than military hospitals.

²⁴⁶ AMSC, pp.387, 570-71.

²⁴⁷ The section is based on ARVA 1951-1954.

²⁴⁸ See ARVA 1954-56; ARSG 1954; William Moore and Charles Shively, "Length of Patient Stay in Army Hospitals," Armed Forces Medical Journal (March 1954), 422-27.

²⁴⁹ COL Ronald Stephens commented on a draft that rehabilitation medicine now focuses on restoring function; I suspect that in the 1950s this was considered a cure.

Developments in medicine helped the VA. Isoniazid (INH) was discovered for the treatment of TB, offering the prospect of substantially cutting expenses. First-generation antipsychotic drugs (e.g. chlorpromazine (Thorazine) were now available, not only decreasing the number of electroshock therapies and lobotomies, but creating the possibility of treating psychiatric patients as outpatients. The VA began experimenting with this, first moving patients from NP hospitals to general medical-surgical, and then discharging some with outpatient follow-up.

The Army was effective at disposing of cases under AR 40-680, routinely meeting the 6-month target for disposition.

Average Duration of Hospitalization (Hospital Admissions Only), total time lost* [in days], and time in bed-occupying status, by area of admission and disposition, U.S. Army, 1954

Area of admission and disposition	All non-battle causes		Disease		Non-battle injury	
	Total time	Occupying bed	Total time	Occupying bed	Total time	Occupying bed
Total Army	25	22	24	21	32	28
Disposition outside U.S.	17	16	19	16	20	20
Disposition in U.S.	31	26	29	24	41	34
Admitted in U.S.	25	21	23	20	33	28
Admitted outside U.S.	170	141	158	134	224	177

* includes time in quarters, on leave, on temporary duty, AWOL, etc., for hospitalized cases.

(Medical Statistics, U.S. Army, 1954, p.16)

Part of this success was treating more patients as outpatients rather than inpatients; antibiotics were credited with substantially reducing the number of hospitalizations and also reducing length of stay. But TSG had also taken direct action, sending hospital commanders a letter pointing out 40-680, and reminding them

medical officers must never lose sight of the primary mission of the Medical Service, namely, conservation of manpower. It is not the intent of [40-680] to minimize required medical care and treatment, or to preclude the use of sound professional judgment in any case.

This was also followed up with visits to keep commanders' minds focused. Another target was paperwork, and the AMEDD, working with the Bureau of the Budget, estimated 20% of days in hospital were due to paperwork, not medical care.²⁵⁰ Steps were taken to remedy that. Moreover, sending long-term patients to the VA did not empty Army hospitals; short-term cases and space-available care for dependents kept the doctors busy. But dependents were ineligible for VA care, and short-term patients were

²⁵⁰ Moore and Shively.

generally cheaper for the AMEDD budget. The federal government would be caring for the patients, but they would be off the Army budget.

The Army Reviews Use Of The VA

In 1956, the Health of the Army report had a six-page review, “Army patients transferred to Veterans Administration Hospitals July 1951-June 1956.” Over five years, 6,942 patients had been transferred; the largest groups were TB (33.6%), NP (29%), neurosurgery (9%), and paraplegics (7.2%). (Unsurprisingly, TB and neuropsychiatric percentages rose after the Korean fighting ended and battle casualties ended.) The peak number transferred in any year was 1,955 in 1954. With the GH system around 11,000 beds, this would have been approximately 17% of beds. There were few trends in the data, except with fewer battle casualties in later years the length of stay dropped. Overall, for these patients, the length of stay somewhat exceeded the 180-day recommendation of AR 40-680, although it came nowhere near the 18-month limit. Health of the Army was overwhelmingly a statistical report, and there were no comments whether the program was good or bad for the AMEDD.

Chapter 5

1956-1973

From the Dependents Medical Care Program to the Volunteer Army via Vietnam

Introduction

From 1950 to the end of the Vietnam War, the Army policy to transfer chronic and long-term patients remained unchanged on paper, but implementation changed radically. The Army did more for its wounded, which translated into more patients being retained for longer periods. Ultimately patients were only transferred after the Army had done as much as it could. Patients from Vietnam were initially treated the same way, held for lengthy periods if they might RTD, but the Army showed little reluctance to send non-RTD patients to the VA for care. When the intensifying war caused a buildup of patients in the Army hospital system, the Army began transferring many more patients to the VA.

During this period the public attitude towards disease changed somewhat. With more pharmaceuticals to treat long-term conditions, the stigma of disease waned. This included mental illness, with wide availability of diazepam (Valium) and growing use of other psycho-therapeutic drugs. More problems could be treated and managed, and the Army moved alongside civilian medicine, treating more soldiers and discharging fewer.

The VA

The Army's attitude was not because the VA had poor care. Qualitatively the VA had generally good care.²⁵¹ In 1959 about half of VA hospitals were affiliated with teaching institutions, and through this period the VA had a rising number of residents (from 3,000 or about 10% of residents in the nation, to 5,300 in 1972) and interns (rising from 100 to 770). The VA also maintained a substantial physical medicine program; there were 100 physiatrists in 1967, with 207 residents in training, compared with an Army strength around 15.²⁵² The system was certainly not perfect, and while there were many trainees, there was more trouble holding onto newly-trained physicians. The physician pool largely

²⁵¹ See ARVA for the period in question, and Hamowy. For a contrary view, see Paul Starr, The Discarded Army: Veterans After Vietnam (New York: Charterhouse, 1973), chapters 3 and 4. Starr does largely blame Congress for administrative problems the VA had.

²⁵² W. P. Blocker Jr., et al, "Physical Medicine and Rehabilitation Service 50th Anniversary (1917-1967)", Military Medicine (July 1967), pp.489-500. The number of Army physiatrists is estimated from data below.

split into those who joined the VA just after WWII and foreign-trained physicians.²⁵³ There would of course be periodic complaints about patients care, perhaps amplified by the ability of complaints to sway Congress to intervene. Evaluation of limited data²⁵⁴ suggests a the VA would often have trouble coping with unexpected changed in patient population. This may be normal; organizations gradually optimize themselves for their main functions and have problems with changes. For example, the VA had grown accustomed to WWII and Korean veterans, and in 1970 Congressional hearings highlighted problems handling Vietnam wounded. In 1968 only 3.3% of VA hospital admissions were Vietnam veterans, which climbed rapidly to 12% in 1971. Vietnam-era veterans felt the VA was run by and for the earlier generation and was unresponsive to their needs.²⁵⁵ Since the number of Korean veterans outnumbered Vietnam veterans as late as 1972, and WWII veterans were more than the others combined, it is not surprising that the VA was largely caring for older men.²⁵⁶ In some areas the VA provided remarkable support: spinal-cord injuries were rapidly transferred to the VA, and physical medicine and rehabilitation was disproportionately used by Vietnam amputees. The VA also handled drug rehabilitation, and in 1973 the VA handled psychological care for returning POWs.

There were some other changes in the patient population treated by the VA. At first it aged, leading to increased research and focus on geriatric medicine. However, 1965 legislative changes reduced the average age somewhat: the Medicare act gave over-65s another option for medical care, and in 1966 Vietnam-era veterans were eligible for VA care. Since the military expanded to fight the Vietnam War, by the late 60s there were several hundred thousand young veterans discharged every year, thus reducing the average age of veterans.

Regardless of the age of the population, the VA maintained a very large hospital system. In the late 50s the daily average census was around 111,000 patients (in

²⁵³ Starr, p.57.

²⁵⁴ The author has not sought every newspaper story about VA medical care; this relies on Ronald Hamowy, Government and Public Health in America, (Northampton, MA : Edward Elgar, 2007), chapter 3 The Veterans' Administration, pp.271-339; Hearings, Oversight of Medical Care of Veterans Wounded in Vietnam, Subcommittee on Veterans Affairs, 1970; and ARVA for the period.

²⁵⁵ See e.g. Starr, pp.56-7. The ARsVA for 1971 and 1973 admit this in the language of government reports.

²⁵⁶ ARVA 1972.

approximately 120,000 beds), and that dipped by 1970 to 85,000 patients in only 102,000 beds.²⁵⁷ This was due to greater use of nursing care, pre- and post-hospital outpatient treatment, and nursing homes. But it was still vastly larger than the Army general hospital system, which was 7,000 beds in 1958 and 4,300 in 1973.²⁵⁸

Through this period Army use of the VA fluctuated. A report²⁵⁹ of patient transfers from 1952-59 showed 7,911 transferred, with a peak of 1,955 in 1954 (as those from Korea, including exchanged prisoners, finished Army hospitalization) and a low of 238 in 1959. The drop was due to a smaller Army, a lack of hostilities, but also the rate of transfers dropped to only 8.2/10,000 Army admissions. The bulk of patients transferred were always TB and NP, and improved treatments available helped reduce incidence, and thus the number of patients to transfer.²⁶⁰ In routine operations (i.e. after the Korean War casualties were transferred) it took roughly 190 days for the Army to transfer a patient to the VA, not far off the six-month standard of AR 40-680. (One unchanged element was military use of the VA in case of a mobilization or war. Discussions were held in 1965-66 but only generalities agreed.²⁶¹ These discussions would lapse until the 1980s; a fuller discussion is in the next chapter, pages 106-109.)

Changes in Medicine

A major factor in changing discharge patterns was the changing nature of medical science.²⁶² Advances in medicine brought about intensive care units, cardiac pacemakers, routine kidney dialysis, organ transplants, ventilators, behavior therapy, radiation therapy for cancers, open-heart surgery, and second-generation psychiatric drugs. More problems could be cured, but many more could be treated, and medicine started thinking about managing conditions as much as curing patients. More therapeutic techniques and drugs played a role in another shift in medicine, from inpatient care to outpatient care. For instance, drugs meant that most TB patients could receive outpatient care and TB

²⁵⁷ See table from ARVA, in Starr p.78.

²⁵⁸ ARSG, 1958 and 1973.

²⁵⁹ "Army Patients Transferred to Veterans Administration Hospitals, 1952-59," Health of the Army Sept. 1960, pp.1-3. Admissions referred to hospital or quarters.

²⁶⁰ Starr, p.56, gives a breakdown of 30% psychiatric, 30% neurological, 10% amputees, and 8% TB patients. This seems remarkably high in neurological cases.

²⁶¹ ARSG 1965, 1966.

²⁶² For a positive view, see Anon. "Progress in the Federal Medical Services, United States Army," Military Medicine (Oct. 1970), pp.841-844, and same title, (Aug. 1971), pp.657-663.

hospitals could be closed or converted. The shift in hospitalization patterns had numerous implications, only some of which will be raised here. For instance, those patients who were hospitalized were now proportionately more acute (“sicker”) than before, changing staffing ratios; with more outpatients care there would be fewer hospital beds for a given patient population, but for the military that might affect wartime surge capabilities.

A corollary of higher acuity for inpatients was the need for more phases of care, and nursing homes and other ‘step-down’ facilities were created to provide care after “maximum benefit of hospitalization” had been reached. Use of this term is deliberate; for the Army the regulations did not change, but medicine had, so “maximum benefit of hospitalization” was no longer the end of formal medical care. The VA would start operating nursing facilities, first alongside hospitals and then as separate nursing homes before residents (not patients) could go to the domiciliary homes. The Army would not operate nursing homes.

Such changes in medicine would mean more-damaged soldiers could be saved and would survive. Among amputees, the percent with multiple amputations rose from 5.7% in WWII to 18.4% in Vietnam.²⁶³ Burn patients also stood a better chance, even those with large surface area burns. Both of these categories of patients would require lengthy recovery times. Rehabilitation would remain a large part of medicine, with physical and occupational therapy extending out of hospitals and into both outpatient clinics and step-down facilities. In FY1966 the VA would employ 20% of American physiatrists, a mark of the emphasis given to rehabilitation.²⁶⁴ The Army Prosthetics Research Laboratory would continue to function, apparently peaking around 40 personnel.²⁶⁵ Beyond the Army, three universities had prosthetics programs (UCLA, NYU, and Northwestern), and the National Academy of Sciences organized a Prosthetics Research Board.²⁶⁶ The VA had a large role in prosthetics, pursuing research for groups

²⁶³ Starr, p.54.

²⁶⁴ ARVA 1966.

²⁶⁵ Information Paper, History of Prosthetists in the U.S. Army Medical Department, 12 Aug 2005.

²⁶⁶ Prosthetists Information Paper; Memo, Report by Maj. Gen. Ward H. Maris (Ret.) of Partial and Uncompleted Survey of the Prosthetics Research Program coordinated by the Prosthetics Research Board, made by Dr. Paul B. Magnuson and Maj. Gen. Ward H. Maris (Ret.) in January 1958 (in Tracy Voorhees Papers, MHI). A substantial literature on prosthetics would grow; the National Academy of Sciences would publish Artificial Limbs: A Review of Current Developments apparently quarterly, coordinating the Committee on Prosthetics Research and Development and the Committee on Prosthetic-Orthotic Education.

the Army did not (e.g. the blind), and at times being the nation's largest purchaser of prostheses, as much as 35% of the market.²⁶⁷

The Army

Army medicine also experienced these changes in the practice of medicine, but also had its own administrative changes, and dealt with a war as well.²⁶⁸ By the late 50s, the Army had adapted to the Cold War. Because modern weapons largely voided the traditional pattern of a wartime mobilization from a tiny peacetime military, the US maintained a large, ready force. The draft provided men directly (in the form of draftees assigned where the military needed them) and indirectly (volunteers who could select their service), and the draft included doctors. The Reserves were large, but with uneven readiness levels. Because both National Guard and Reserves had political clout, it was easier to draft more 18-year olds than to mobilize reserve component units. Thus the size of the military would wax and wane as Cold War crises came along, but, with doctors subject to the draft, that posed relatively little problem to the AMEDD since more physicians were available through the draft. (Around 80% of physicians were draftees.) Since draftees served two years, and volunteers might serve only three, the patient population stayed quite young.

The doctor draft not only brought in General Medical Officers but residency-trained specialists. The Berry Plan (named for Dr. Frank Berry, a long-serving ASD(HA)) deferred physicians for the duration of their specialty training; they then served their two year obligation and (mostly) left the military. Retention rates for draftee physicians were very low, usually under 10%.

Army CONUS General Hospitals as of FY1958 and disposition

Name	Location	Date opened	Size	Closed
Army and Navy	Hot Springs AR	1887	150	Transferred to state 1959
William Beaumont	El Paso TX	1921	600	
Brooke	San Antonio TX	opened 1907 (as station hospital)	975	
Fitzsimons	Denver CO	1918	1025	1999
Letterman	San Francisco CA	1898	875	1995
Madigan	Tacoma WA	1942 (as station	500	

The VA has published (through 2008) 44 volumes of the Journal of Rehabilitation Research and Development. <http://www.rehab.research.va.gov/jour/jourindx.html>

²⁶⁷ ARVA 1966.

²⁶⁸ This section is largely based on the ARSG, 1958-73.

		hospital)		
Murphy	Waltham MA (greater Boston)	late 1940s	150 (closed 31 Dec 57)	closed 1957
Valley Forge	Phoenixville PA	1943	900	closed 1975
Walter Reed	Washington DC	1909	1250	scheduled for BRAC 2005

Sources: ARSG 1958; Hospitalization And Evacuation, Zone of the Interior pp.304-13; internet research

The Changing Military Patient Population

1956 was also the beginning of the Dependents Medical Care Program (then known as Medicare, to become CHAMPUS and ultimately TRICARE; since the term Medicare was used for a very different government program, CHAMPUS will be used in this study). From 1884 the military had offered healthcare to dependents on a space-available basis. Generally, there was space available, but there was no guarantee that a particular medical specialty would be available everywhere. (The growing specialization of medicine made this more of an issue in the 1960s. In 1884 or even 1934 it was hardly a concern.) CHAMPUS guaranteed that a service would be provided, with the government paying for care from the civilian sector if the military could not supply it. This substantially changed the mix of physicians needed; the Army trained allergists and cardiologists in Army hospitals, while sending endocrinologists and pediatric hematologists for training in civilian hospitals.²⁶⁹ Some of these programs had a preventive medicine or health maintenance role for the Active Duty population. But, with a draft available to bring in both 1) healthy young men, and 2) trained young physicians, the AMEDD's operating these training programs strongly suggests it wanted to. On the other hand, sub-specialty training programs supported retention and GME for specialty programs; pediatric hematologists helped train pediatricians.

Since CHAMPUS was soon expensive (and got more expensive as Congress added more services, including what is now the Exceptional Family Member Program²⁷⁰ and from 1966 including retirees and their dependents), there was immediately pressure for the military to provide as much care as possible, sending as few patients as possible to (more expensive) civilian care. CHAMPUS would also force the Army to treat conditions

²⁶⁹ ARSG 1966.

²⁷⁰ ARSG 1966.

it would ignore in a soldier by discharging him; chronic and psychiatric dependents were an early problem, and they could not be given a CDD nor sent to the VA.²⁷¹

CHAMPUS patients intersected with a growing GME program, which mainly trained the Regular Army physicians. To gain the broad experience needed for board certification, a doctor had to see a variety of patients; this meant the AMEDD wanted to care for dependents, retirees, and veterans.²⁷² Doctors sought to treat chronic patients, contravening E.O.10122 and 10400, without (apparently) even considering them; indeed chronics were “a feather in the cap.”²⁷³ Active-duty patients became a minority population for the AMEDD. In 1959 (only three years after CHAMPUS started), active-duty personnel were a minority of outpatients. The Army also provided a small number of beds (250-300 apparently) to the VA.²⁷⁴

Combined with Congressional pressure to minimize costs and GME needs for a mixed patient population was a third force. Surgeon General Leonard Heaton was an outstanding clinician (while Surgeon General he personally operated on Pres. Eisenhower) and he increased GME. During the Vietnam War the number of residencies and fellowships continued to increase, largely to help recruit and retain the Regular Army cadre of physicians, and GME became a balancing act against wartime needs. In 1962, 66% of Regular Army physicians were board-certified or board-eligible.²⁷⁵ In FY1966 the ARSG lamented that some physicians had been sent to Vietnam without replacement in the teaching hospital system. Heaton would expand the GME program even during the Vietnam War. By 1967, 210 officers were starting their residency and 694 were in some phase of residency training.²⁷⁶ This actually expanded in 1968 amid extreme pressure from wartime casualties to 225 new residents, and it rose every year through 1972.²⁷⁷ In

²⁷¹ ARSG 1958.

²⁷² In 1967 the military received permission to factor retiree care into plans for future medical facilities; retiree care was literally built into the AMEDD. ARSG 1967.

²⁷³ Julian A Sterling, Guest Editorial: Chronic Illness and the Armed Forces, Military Medicine (April 1966), p.385.

²⁷⁴ ARSG 1960. Reporting of this data was patchy, hence the caveat “apparently.”

²⁷⁵ ARSG 1962.

²⁷⁶ ARSG 1967.

²⁷⁷ ARSG 1968. Overall numbers dropped to 693. ARSG 1969, 1971, 1972. It may have risen in 1973, but the creation of Health Services Command (the predecessor of Medical Command) separated command of the hospitals – and thus the GME programs – from The Surgeon General. His 1973 report thus does not contain GME data.

1972 when the AMEDD was facing the end of the doctor draft, the response was to reinforce GME as a recruiting/retention tool.

The Vietnam War

In a world where non-Active Duty patients used the bulk of AMEDD resources, the Vietnam War did not get immediate attention. Nor would it in the VA, where by 1973 Vietnam wounded were only 2% of the beneficiary population.²⁷⁸

The Army GH system stayed small through the war, and also lagged behind the intensity of fighting. This may have been due to optimistic forecasts of progress in the war within the Army, a desire not to expand hospitals (and thus forecast casualties), or other reasons. Review of the Surgeon General's morning conferences shows Heaton concerned with budgets, personnel, and how to support the Vietnam buildup without slighting on-going patient care. Both Congress and the Pentagon were reluctant to plan for a long (or large) war, and thus spending on physical plant was apparently deferred. For instance Valley Forge General Hospital was not part of AMEDD long-term plans, and it appears some renovation projects were slowed for this reason.

In 1957 the Army operated 7,000 GH beds; that dropped below 6,000 through 1965, then climbed back to around 7,000 in 1967 with 8,400 forecast for 1968.²⁷⁹ Double the number of patients went through debarkation hospitals in 1966 compared with 1965, and the bulk of those would have been from Vietnam; in 1967 22,521 came back from the Pacific alone.²⁸⁰ In 1965 Surgeon General Heaton's main concern seemed to be moving patients around in the Army GH system; when Walter Reed was crowded he suggested moving patients to Valley Forge. As the year came to an end Heaton and his Deputy agreed the AMEDD needed long-term plans for WIA that would probably include CONUS hospitals, and Valley Forge General Hospital was their leading candidate.²⁸¹

In 1966 Heaton began using station hospitals (augmented with additional medical staff) for WIA patients. This was an explicit lesson remembered from Korea. At one

²⁷⁸ Starr, p.56.

²⁷⁹ Data drawn from the ARSG. Most of these reports give numbers of patients in hospital at beginning or end of FY rather than the number of operational beds. For this study a utilization rate of around 90% has been assumed.

²⁸⁰ ARSG 1966, 1967.

²⁸¹ SGM 5 and 8 Oct 1965, 10 Dec 1965.

point, with Walter Reed “bursting at the seams” the ASMRO was told to temporarily send no more patients. As early as March (roughly a year after the first US ground troops entered Vietnam) Heaton said that Walter Reed needed to discharge patients faster. It had 1,150 patients, with 200 at the Forest Glen annex and 400 on convalescent leave; a day room had already been converted to ward space. Heaton was upset about a particular case of a comatose patient brought back from a VA hospital, and said specifically “we cannot afford to keep long term patients in our hospital system.”²⁸²

Transferring patients to the VA naturally lagged, as it had to unless the GH system needed to be emptied for a rush of patients. The ASMRO would transfer 1000-1200 military patients to the VA per year until 1967, when it roughly doubled to 2,100. (Measured against beds in the GH system, this is roughly 17% in 1967 and 25% in 1968. Numbers increased to 2,949 in 1968, but spiked to over 4,500 in 1969 and peaked at 4,605 in 1970.²⁸³ Based on a patient census of 10,300 at the beginning of FY1970, the GH system had roughly 12,000 beds and thus the transfers to the VA were around 38%.) One datum shows just over 3,000 Army patients in Navy hospitals and just under 1,000 in USAF hospitals for FY1969.²⁸⁴ Late in 1967 the Director of Plans, Supply, and Operations recommended TSG write to GH commanders urging them to discharge patients faster.²⁸⁵ That year about half the patients in GHs were from Vietnam, and there were not personnel to expand the GHs.

1968 would be the crisis year, as the CONUS hospital system had not been expanded but was largely filled with patients, and then had to cope with the flood of casualties after the ‘Tet’ offensive. On 19 January 1968 almost half the GH beds had Vietnam patients, and still more were in Station Hospitals or on convalescent leave. Tet was on 31 January, and by 9 February 1,200 patients had already been flown back and there were 250 more per day expected for the next week. CONUS hospitals were already operating at 86% occupancy, about 2,000 patients above programmed staffing levels. Heaton suspended the standard policy of hospitalizing patients close to their home,

²⁸² SGM 18 Feb and 18 Mar 1966.

²⁸³ Army-only numbers are 1966:448, 1967:903; 1968:1775; SGM 31 Jan 1939. Data are not available after 1970; the ASMRO became an Executive Agency of the Air Force around that time and filed reports elsewhere. An enquiry revealed that a new computer system only has data back to 2001.

²⁸⁴ ARSG 1969, p.35. Unfortunately it is not clear if these are totals for the year or a snapshot at year-end or year-start.

²⁸⁵ SGM 27 Oct 1967. Heaton apparently deferred this action.

instead sending patients to the empty beds; he also urged hospital commanders to send non-RTD patients to the VA. On 13 February the situation had deteriorated further, with more patients coming in and the decision that “evacuees must be accommodated within resources currently available in CONUS hospital system” meant that WIA would not be sent outside the military hospital system.²⁸⁶ Heaton had various recommendations: longer working hours and weeks, deferring elective treatments, moving staff from outpatient care to inpatient care, tightening admissions criteria, and keeping an eagle eye on dispositions, especially for the longest-staying patients. A month later the initial shock of Tet was over and transfers to the VA were up from the normal of 80 per month to 140 in three weeks, and the Army was considering expanding the CONUS hospitals. However, Heaton thought of the VA only for patients “who had received all possible treatment and rehabilitation in Army hospitals.” (Army plans were to expand the Station Hospitals, presumably because of more basic trainees; Heaton wanted to expand the GHs or at least the specialized treatment centers at SHs.) In April Heaton requested a 4,000-bed expansion (presumably personnel for the beds), but the Army cut that back 90% saying that Tet was abnormal.²⁸⁷ A week later there was discussion of one reason the GH system was filling up again: PEB boards did not want to travel to VA hospitals.²⁸⁸ The AMEDD reaction was robust: “we can’t hold patients in the hospitals and if need be [the boards] will have to go to the VA hospitals to get their information.”²⁸⁹ By October, the AMEDD had run out of NP beds, and there was no space OCONUS to hold more patients, which were running 230-250 per month. The solution was asking the VA for beds, which would possibly have breached Heaton’s policy on sending patients to the VA before “all possible treatment and rehabilitation.”²⁹⁰ Heaton admitted the hospitals were overcrowded, and curtailed admission of orthopedic and neurosurgery patients due to lack of facilities.²⁹¹

²⁸⁶ SGM 13 Feb 1968.

²⁸⁷ For a longer description, see Lt. Gen. Leonard Heaton, “Department of the Army,” Military Medicine, February 1969, pp.86-89.

²⁸⁸ Apparently PEB procedures have changed, because in 1968 the personnel who comprised the board could travel but declined to; in 2008 boards meet in fixed locations. I am grateful to COL Ronald Stephens for pointing this out.

²⁸⁹ SGM 3 and 10 May 1968.

²⁹⁰ SGM 19 Jan 1968, 9 and 13 Feb 1968, 22 Mar 1968, 25 Oct 1968. Neuropsychiatric was still the term used in briefing TSG.

²⁹¹ ARSG 1968.

Even though 1969 was the bloodiest year of the Vietnam War (at least for the US), the inpatient census in GHs dropped and would continue to drop as the US handed more responsibility to the South Vietnamese military. In March 1969, even as Army manpower moves were hampering manning the SHs (personnel were being transferred to strategic readiness forces as the Army refilled units that had been depleted to support operations in Vietnam), the Army was establishing organ-transplant facilities. In April there were questions in the press about why the military was not using the VA, questions to the ASD(HA) and directly to the Army. It is easy to imagine why BG James Wier denied any crisis: he was asked if the situation would be eased by declaring a national emergency. Obviously the AMEDD would have an easier time, but saying so would have created a furor in the press that the Army was over-stretched and that the Nixon Administration was denying wounded soldiers needed resources. By July transfers to the VA were around 195 per month but “the situation in our hospitals is very critical” and Letterman GH wanted to curtail treatment to retirees and their families.²⁹²

Transfer of blind and paralyzed patients to the VA apparently operated without delay, as the Army did not emphasize rehabilitation.²⁹³ When the question of rehabilitating paraplegics and quadriplegics arose, the Director of Professional Services declared “Our position was again stated that VA has the mission and is doing a good job!”²⁹⁴ The only concern was speeding up the administrative hurdles. In 1959 the Army had physical medicine services in only 7 hospitals, with 3 residency programs and a total of 22 graduates since 1948.²⁹⁵ The number of physiatrists was low, and the physiatry residency programs were too small to warrant mention in the Annual Reports. Little data has been found, but in 1960 the Army was projected to have 18 physiatrists, a small number indeed, but substantially over the estimated requirement of only 10. The number of OTs and PTs was much larger (256 PTs and 119 OTs in 1970, after the bloodiest year

²⁹² SGM 7 and 21 Mar 1969, 11 Apr 1969, 3 Jul 1969.

²⁹³ See Col. Paul W. Brown MC (Ret.) “Rehabilitation of the Combat-Wounded Amputee,” in Col. William E. Burkhalter MC (Ret.) Surgery in Vietnam: Orthopedic Surgery (Washington, DC: GPO, 1994), pp.189-209. Brown ran an amputee rehabilitation program at Fitzsimons Army General Hospital that involved skiing, swimming, and horseback riding. These helped patients, but it is unclear why the Army needed to operate such programs with an effective VA.

²⁹⁴ SGM 3 Nov 1967. Original emphasis.

²⁹⁵ Mastellone, “Physical Medicine in the Army: History and Development.” Mastellone also complained the Army had trouble retaining physiatrists, blaming greater opportunities in other branches of medicine; he did not fault E.O.10400.

in Vietnam), but still modest. PTs were roughly 40% of the AMSC, and OTs 20%; Corps strength was roughly 450 before and after Vietnam and rose to roughly 600 at the peak of the war. Enlisted aides supplemented officer personnel. “Physical medicine helper” was deleted in 1959, but physical reconditioning specialists and occupational therapy specialists survived, as did orthopedic bracemakers, prosthetists, and plastic eye makers.²⁹⁶ Much of the training was on-the-job instead of formal courses, but a short course for PT aides began in FY1965 and a longer course for OT aides began in FY1971. From 1965, a few reservists were brought on Active Duty for on-the-job training in rehabilitation specialties.²⁹⁷

There was some modest rehabilitative work in theater. As in WWII and Korea, combat stress cases were treated close to the front to maximize RTD. Vietnam saw another kind of rehabilitation, namely drug rehabilitation. The 6th Convalescent Center shifted from convalescence of WIA to treating addicts, an area the Army had previously paid little attention. An average of six PTs were deployed per year in Vietnam over 1966-73; one OT was sent to help with drug rehabilitation.²⁹⁸ PTs not only helped patients return to duty, they rediscovered something found in WWI: early physical therapy helps speed recovery of even patients who would not return to duty.²⁹⁹

This highlights another development: the Army treated patients it would previously have discharged. In part this was related to the draft. It was little punishment to discharge a draftee if he smoked marijuana; in fact some might do that deliberately if it brought a discharge. Such administrative or disciplinary discharges would only be effective with the much smaller professional core in the Army. But it was also part of a broader trend. In 1959 the Army began treating schizophrenic troops, managing to return 50% to duty.³⁰⁰ Not only was schizophrenia treatment now possible, but 1)the Army embraced it even when the recovery rate was moderate, 2)when there was no guarantee

²⁹⁶ In 1966 there had been discussion of reclassifying Physical Reconditioning Specialist and Occupational Therapy Specialist as special services career (instead of medical) groupings, but that ended. No reasons have been seen. SGM 9 Nov 1966.

²⁹⁷ ARSG 1965.

²⁹⁸ Information Paper, Army Medical Specialist Corps in Vietnam, Col. (Ret.) Ann Ritchie Hardwick, online at <http://www.vietnamwomensmemorial.org/pages/pdf/ahartwick.pdf>

²⁹⁹ Carl A. Hertzman, “Rehabilitation of Casualties in a Combat Theater,” American Journal of Physical Medicine, (1968), pp.113-117. Hertzman was with the VA after his Army service.

³⁰⁰ ARSG 1959.

the patients would stay cured, and 3) non-schizophrenic draftees were readily available. In this situation, it is easy to see how the number of patients transferred to the VA was small. (Treating schizophrenics is even more remarkable given that in 1958 the Army regained access to St. Elizabeths.³⁰¹) Alcoholics were also treated instead of discharged, using some of the same techniques used for schizophrenics.³⁰²

Yet the VA had more and broader rehabilitation programs. It is emblematic that when Howard Rusk persuaded Pres. Johnson to fly a planeload of Vietnamese paraplegics to the U.S. for care they were sent to a VA hospital rather than an Army one.³⁰³ The VA would train a handful of Vietnamese medical personnel in paraplegic care.

The End of an Era

As the Army was grappling with the end of the draft and the beginnings of the Volunteer Army, Pres. Nixon signed Executive Order 11733. This essentially gutted 10122. But times had changed. Uniformed personnel were a minority of the AMEDD workload, and the GME program needed retirees and complex, chronic patients. Since GME was now central to the AMEDD's physician recruiting (and especially retention) plans, the broader mix of patients from which to choose was a benefit instead of a problem. If the government was going to pay for their care through the VA, the Army, or CHAMPUS, why should the Army not take care of educationally-useful patients? E.O. 11733 received only passing mention in the ARSG, and was presented as a bump: it inequitably sent certain retirees away from the Army.³⁰⁴

³⁰¹ ARSG 1958.

³⁰² ARSG 1960, 1961.

³⁰³ ARVA 1966.

³⁰⁴ ARSG 1974.

Chapter 6

1973-2001

The All-Volunteer Force charts its course

Introduction

Under Executive Order 11733, the Army could decide when (or even whether) to transfer patients to the VA, so it is appropriate in this section to focus on the Army. Right from the start, there were few patients transferred: the ASMRO only requested spaces “for uniformed services personnel who required further hospitalization after separation or retirement.”³⁰⁵ When the DoD, Office of Management and Budget, and Department of Health, Education, and Welfare assembled for the Military Health Care Study in 1975 there was not any consideration given to using the VA.³⁰⁶

However, there have been numerous steps taken to work with the VA and with civilian healthcare organizations to save money. The Army has worked with outsiders in many and varied ways to save money, but not to treat casualties of war. There have been plans for use in wartime, so the military has been pragmatic about huge numbers of casualties but much more insular with small numbers. In 2002, according to then-ASD(HA) Winkenwerder,

DoD’s vision of its relationship with the VA is that of a mutually beneficial, proactive federal partnership that optimizes the use of federal resources and infrastructure to improve access to quality health care and increase the cost-effectiveness of each department’s operations while respecting the unique missions of the VA and DoD medical departments.³⁰⁷

The exceptions were a relative handful of categories that were exceedingly unlikely to return to duty: spinal cord injuries, traumatic brain injuries, and blinded personnel.³⁰⁸

There were numerous pressures on the Army during these three decades, ranging from personnel shortages, changes in medicine, a changing patient population, and rising healthcare costs. All of these were strong pressures. Independent of these the ethos of the All-Volunteer Force, the professional military, evolved as well. Despite this being the

³⁰⁵ ARSG 1975. Numbers have not been consistently reported. See below for what has been found.

³⁰⁶ Report of the Military Health Care Study, December 1975, National Library of Medicine.

³⁰⁷ ASD(HA) Policy Memo 02-022, 18 December 2002, “Policy for Department of Veterans Affairs Participation in TRICARE.” This repeated, almost word-for-word, policy under the Clinton Administration. ASD(HA) Policy Memo 00-004, 16 May 2000, “Use of Health Care Facilities of the Department of Veterans Affairs under TRICARE and the Supplemental Health Care Program.”

³⁰⁸ There was a strange note in the ARSG 1974 that mentally incompetent soldiers would not be transferred to the VA unless “all interested agencies and authorities have been advised.” No data has been found about transfers.

recent past, sources are paradoxically short. Some are not open, some are poorly indexed, and after the demise of the clerk-typist some records have not been kept; in addition it is hard to document an ethos.

In this period the capabilities of medicine had expanded so that many who would have been written off as “cripples” or disabled a few decades previously were salvageable. The Americans With Disabilities Act became law in 1990, suggesting that the public (through their elected representatives) had changed their view of physical limitations. Disabilities were something that could be overcome, and need not be hidden. Psychiatric drugs had become pervasive enough that many mental hospitals were closed and care in the community became routine. Parents were seeking to have their children labeled as special education or diagnosed with Attention-Deficit Hyperactivity Disorder. For the Army it meant that patients might need lengthy treatment, and that the public would expect such treatment. A question would be whether the Army delivered this treatment or other organizations would.

This study will look at the developments to the end of 2001, as the military was on the edge of its first sustained combat operations since 1970.

Personnel Shortages in the AMEDD

In the late 1970s and early 1980s the AMEDD was short of physicians.³⁰⁹ (When providers were scarce, the Army prioritized care to active-duty personnel.³¹⁰) The Berry Plan was delivering the last few draft-obligated physicians, but the Uniformed Services University for the Health Sciences and Health Professions Scholarship Program were not yet delivering adequate numbers. The military response was to use the poorly-titled ‘physician extenders,’ something that was in line with the practice of medicine in the

³⁰⁹ 1977 was the only year with a severe numerical shortfall, but many physicians were in GME and positions not caring for patients, and some still needed to complete internship. In 1978 there were 1443 GME slots, over one-third of the Medical Corps. LTG Charles Pixley, “Army Medical Department,” Military Medicine (Sept 1979), pp.580-587. In the absence of annual reports after 1980, annual articles in Military Medicine and U.S. Medicine under the Surgeon General’s name are used as proxies.

1974		1975		1976		1977		1978		1979	
Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.
4375	4269	4474	4490	4373	4448	4036	4713	4126	3995	4391	4201

Medical Corps strength, last day of fiscal years. Source: prepared at Center of Military History from data in the (former) Medical Records Collection. Authorizations differed from the “peacetime end strength requirement” let alone the “recognized end strength requirement.” ARSG 1976-80.

³¹⁰ LTG Charles Pixley, “United States Army Medical Department: Progress and Plans,” Military Medicine (Feb 1979), pp.94-98.

civilian world. (This raises the incidental point that during the draft the military might have used physicians less efficiently than the civilian world because it did not have to pay market price for them.) From the early 70s Physician Assistants were in use, first as warrant officers and later holding full commissions. Nurse practitioners (including nurse midwives) were used. PTs and OTs were used to treat musculo-skeletal conditions of outpatients, and helped establish sports-medicine programs, including research in exercise physiology. OTs also moved outside hospitals into such programs as drug treatment and smoking cessation. (This may have cut into the numbers available for rehabilitation of in-patients.) Dieticians began counseling patients about diet as well as of overseeing hospital kitchens.³¹¹ Podiatrists were recruited when orthopedic surgeons were in short supply.³¹² MSC administrative officers were used to release physicians and dentists for patient care. There was even an attempt to automate diagnosis and staff clinics with enlisted personnel, the Automated Medical Outpatient System and the AMOSIST, Automated Military Outpatient Systems Specialist.

Physicians that were available were accepted, including foreign-born physicians, Americans who had gone to foreign medical schools, and older physicians. These would lead to quality problems in the 1980s, heightened by media and Congressional attention. LTG Quinn Becker made improving the AMEDD image and boosting spirits of AMEDD personnel priorities because the organization had such bad press. (Around the same time the AMEDD had to admit it could not handle the casualties from a war against the Warsaw Pact, which is unlikely to have helped morale.)

Against this background of scarce physicians, GME became the key recruiting/retention tool.³¹³ Since 1950 it had been important for the skeleton of Regular Army physicians under the flesh of the 'doctor draft,' but now it was crucial for all AMEDD physicians. Aside from TDA missions of preserving healthy forces in peacetime and treating wounded in wartime, wartime evacuation hospitals and general hospitals needed board-certified staff. GME not only provided peacetime manpower, it trained those people for their deployed wartime mission of caring for complex medical and

³¹¹ ARSG 1976-80. PTs were tested in a Medical Company for neuromusculoskeletal problems. LTG Bernhard Mitemeyer, "Army Medical Department," Military Medicine (Nov 1982), pp.918-28.

³¹² ARSG 1976-80.

³¹³ ARSG 1976-80 has a lengthy discussion, pp.181-91.

surgical patients. As the GME program matured and recruitment could become more selective, the Army achieved excellent first-time-pass rates for board certification, to the point the statistic is periodically cited as evidence of high quality medicine in the Army.³¹⁴ Interestingly, from 1993 Congress has used priorities for Medicare money to urge civilian GME into primary-care specialties rather than sub-specialty care.³¹⁵ The military GME program has evolved independently.

Rehabilitation Programs in the Army and VA

The change to a professional Army may have affected rehabilitation. In 1968 it was not cost-effective to rehabilitate young soldiers. Little had been invested in their training, and they could easily be replaced with another draftee. (The Army did honor its obligation to them, as documented above.) However, the problems of recruiting and retaining volunteers created added pressure to rehabilitate those who would previously have been discharged administratively: drug and alcohol abusers. The cost to recruit and train them could be calculated, as could the chances of rehabilitating them for continued duty. The ‘cost’ to the Army’s reputation of not rehabilitating them was an intangible, varying according to the eye of the beholder.

In 1970s, the Army started courses on drug and alcohol training for medical personnel, and also in rehabilitation for abusers.³¹⁶ In 1980 the Army opened an inpatient alcohol rehabilitation center, eventually doubling the size of the program after success.³¹⁷

In 1981 the Army reported progress in lip-reading and auditory training for aural rehabilitation; the goal was “optimum rehabilitation,” and it is not clear whether RTD was a factor or not.³¹⁸ The Army Audiology and Speech Center was researching brain-stem evoked response audiometry.

³¹⁴ As was the credentials verification standards: LTG Frank Ledford, “Army ‘Innovative’ in use of Funds,” U.S. Medicine, January 1989, and “Army Increases Combat Readiness,” January 1990.

³¹⁵ <http://www.aamc.org/advocacy/library/gme/gme0001.htm>

³¹⁶ ARSG 1974.

³¹⁷ LTG Charles Pixley, “Army Medical Department,” Military Medicine (Sept 1979), pp.580-587. LTG Bernhard Mitemeyer, “Army Total Fitness Program a Success,” U.S. Medicine, 15 January 1983. DODI 1010.6 (Rehabilitation and Referral Services for Alcohol and Drug Abusers, 13 March 1985) allowed transfer of RTD patients (and family members) when the services wanted to use VA facilities; non-RTD cases were generally to be transferred to the VA.

³¹⁸ LTG Charles Pixley, “Significant Strides Recorded by Army,” U.S. Medicine 15 January 1981 and “Army Medical Department,” Military Medicine, (Sept 1981), pp.611-620.

In 1974 the Army juggled its enlisted personnel, deleting the 91K Physical Reconditioning Specialist and reclassifying to 91J or 91L, PT or OT Specialists. Only 81 students would start the two courses, suggesting a low need for OT and PT. Until the late 1990s manpower surveys did not list enlisted strength, and the 91J and 91L were too small to maintain as separate Military Occupational Specialties but became Additional Skill Identifiers for 91B by 1995. By 1998 the Army authorized 297 enlisted, and by 2001 that climbed to 307, although there was an end-strength of 340.³¹⁹

In the drawdown after Operation Desert Storm, the Army deleted MOS 42C, Orthotist and Prosthetist, with positions civilianized to GS-667. 42Cs did not deploy, and an Army increasingly focused on war fighting was eliminating non-deploying positions. By the mid-1970s the Army Prosthetics Research Laboratory had been closed down.³²⁰

Three groups of officers focused largely on rehabilitation: physiatrists, OTs and PTs. It is hard to correlate authorizations and end-strength of any of these groups, but physiatrist authorizations are always low, and all groups rose in the late 1980s and fell in the “peace dividend” of the 1990s.

FY	Physiatrist		Occupational Therapist		Physical Therapist	
	Auth.	End	Auth.	End	Auth.	End
82	26	25	88	88	188	190
84	32	28	93	96	200	194
86	17	22	94	91	196	206
88	17	40	93	88	202	202
90	17	40	93	88	201	207
92	19	41	118	84	253	196
94	12	37	70	82	152	186
96	14	34	77	72	167	187
98	17	24	69	74	157	182
00	18	32	72	78	159	193
01	25	31	71	78	159	202

Source: Department of Defense Health Manpower Statistics, Fiscal Years as given

Recalling the use of OT and PT in primary care positions, and support to (among other programs) the Exceptional Family Member Program, the numbers available for rehabilitation work in TDA facilities was likely well below total numbers. Civilian employees were hired as well to supplement the uniformed personnel, although very few

³¹⁹ AR 601-210, Regular Army and Army Reserve Enlistment Program, 28 Feb 1995; Department of Defense Health Manpower Statistics, Fiscal Years as given.

³²⁰ Information Paper, History of Prosthetists in the U.S. Army Medical Department, 12 Aug 2005.

physiatrists were needed, perhaps because the Army was already overstrength.³²¹ By the 1990s, with relatively low absolute numbers of physiatrists, they mainly handled Active Duty patients, and other beneficiaries were referred to civilian providers. Perhaps half the staff in OT and PT clinics were civilians, roughly the same military/civilian balance as elsewhere in 1990s Army hospitals. Army PTs handled almost wholly musculo-skeletal injuries (including the few wounds) of Active Duty personnel, with other patients solely to support GME programs. “Long term rehabilitation, especially for the amputee, head injury, neurologic, and pediatric populations was not done in the military MTFs. [PTs] focus and manpower were directed towards the musculoskeletal injuries pursuant to low intensity conflict and training.”³²² Other factors also interacted. Efforts to reduce length-of-stay for inpatients (and the shift from inpatient to outpatient care, including surgery) meant much rehabilitation work shifted to skilled-nursing and specialist rehabilitation facilities.³²³ Since the Army operated hospitals and clinics, but not nursing and rehabilitation homes, such patients likely left the Army system. Military patients could go to the VA, while beneficiaries would go to CHAMPUS/TRICARE contractors.

In contrast, the VA had around 4,000 rehabilitation personnel and 1,400 rehabilitation beds.³²⁴ It would annually provide around 10,000 limb prostheses and 19,000 aids to the blind.³²⁵ The Army made limited, specific, use of the VA. Military patients transferred were mainly spinal-cord injuries, and fluctuated in numbers: from 1975-80 numbers were roughly 85-150 per year.³²⁶ (These were patients from the Armed Services Medical Regulating Office, and not all Army. Moreover, this number seems high for VA-eligible patients, i.e. Active Duty and retirees; the ASMRO may have been facilitating transfer of civilian emergencies.) Yet the military was not taking much time in sending patients: in 1975 none of the ASMRO patients was in a military hospital more

³²¹ This discussion of Army physical medicine is informed by an interview with COL Ronald Stephens, physical medicine consultant, 28 February 2008.

³²² Email, Rebecca Hooper (Director, Center for the Intrepid, PhD physical therapist, former chief of the Army Medical Specialist Corps), to author, 4 March 2008. The point was reinforced by emails from COL Andrea Crunkhorn on 4 March and 7 April 2008. While there are PTs with focused areas of expertise, PTs handle different patients according to the population of their facility and do not solely focus on amputees, retirees, or any other patient population.

³²³ Email, Rebecca Hooper to author, 6 March 2008.

³²⁴ ARVA 1988.

³²⁵ ARVA 1987.

³²⁶ ARVA 1975, 1977, 1978, 1979, 1980 all mention spinal-cord injury patients that the ASMRO “assisted in transferring.”

than six months, and in 1977 two-thirds of patients were moved within 30 days of injury. Maximum benefit of hospitalization was not a factor for these patients.

Otherwise, the VA had extensive drug and alcohol treatment programs. It also had substantial psychiatric facilities. In 1986 it averaged 22,500 psychiatric beds with 17,000 psychiatric patients per day. There were more than 1.5 million outpatient visits, and the total number of psychiatric patients treated was almost 200,000.³²⁷

Changes in Medicine

Over these three decades healthcare has become ever more specialized. Physicians have gone beyond specialty boards to sub-specialties. The pattern has held in physician extenders; nurse practitioners are not all interchangeable, and there are specialty foci among physical therapists. Advances in drugs have meant more health problems are “conditions” that can be “managed,” and that (along with the cost of inpatient care) has reinforced the shift from inpatient care to outpatient care. As an example, instead of the risk and cost of surgery for stomach ulcers, there are now drugs that can be taken. As medicine has advanced, lives have been extended, albeit living with “conditions,” and rehabilitation facilities have proliferated to improve quality of life as well as quantity.

Better surgery has also lowered trauma fatality rates; in the military this means lower Died of Wounds rates. But surviving acute trauma often means patients have suffered more damage and leads to longer and more complex recoveries. In a situation with a steady inflow of patients needing care, and the time needed for care also increasing, hospitals run the risk of being a bottleneck. A pair of changes in standards of care had particular effects on the military. First, as outpatient care has increasingly replaced inpatient care, the acuity of the remaining inpatients has increased. In previous generations hospital capacity largely depended on space available for patients, while now it largely depends on how many staff are available to care for the very sick. Second, the changing expectation of hospital care is for private or semi-private rooms. It is vastly harder to create space for extra patients in hospitals built with 1- or 2-person rooms than the open-bay wards of WWII or even 4-person rooms.

³²⁷ ARVA 1986.

One change in psychiatry was the recognition of Post-Vietnam Syndrome that was later retitled Post-Traumatic Stress Disorder.³²⁸ Controversial from the start, in a sense it was diagnosed by Congress, which mandated that the VA provide care for veterans who were having trouble readjusting. Since care started with the VA, it seems that the Army did not particularly emphasize treating the new disorder. Moreover, since PVS was not official until 1980, the bulk of potential patients had left the military, either because their term of service had expired or because their symptoms meant they could no longer function in a military setting. Army psychiatric care is certainly available for PTSD patients, but the Army still emphasizes controlling and ameliorating combat stress through Combat/Operational Stress Control Detachments. It may be that the Army never develops long-term care for patients with serious reactions because they will be unable to continue on Active Duty and thus will leave the military.

Prostheses have advanced, some now including their own microcomputers. In some cases, prostheses are more efficient at some functions than the 'normal' human body.³²⁹

Remarkably, one thing that has not changed is the Army's willingness to retain partially disabled personnel.³³⁰ In late 1946 the Army allowed partially disabled veterans who had critically needed skills, or were trainable for such skills, to reenlist. As was only reasonable, they had to be otherwise healthy and capable of performing the duties of their new MOS. Initially restricted to combat-wounded enlisted WWII veterans the practice gradually broadened to officers, other time periods, and injuries or disease. As of 31 January 1953, 630 personnel were on active duty, and the main problems were eye impairments (72), upper extremity (105), and lower extremity (192). 123 were amputees, with 33 missing finger(s) and 59 missing legs. These 630 men held a variety of positions, but a plurality of officers (57 of 163) were tactical unit commanders while the largest

³²⁸ Due to the controversial background of the diagnosis of PTSD, it has been well covered in histories. See Ben Shepherd, A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century (Cambridge, Mass: Harvard, 2001), chapter 24 and William Kelly, ed., Post-Traumatic Stress Disorder and the War Veteran Patient (New York: Brunner/Mazel, 1985), especially chapter 1.

³²⁹ Carbon-fiber blades of a double leg amputee had 30% more mechanical advantage and allowed running at the same speed using 25% less energy than a normal runner. "Amputee Pistorius barred from Beijing Games," Reuters via Washington Post.com, 14 Jan 2008. The Defense Advanced Projects Research Agency is currently investing \$50 million into Revolutionizing Prosthetics.

³³⁰ This section is based on the only report discovered about this program, Health Of The Army July 1953, "Disabled Personnel," pp.8-13.

group of enlisted (69 of 467) were administrative NCOs. In 1951 the Secretary of the Army, Frank Pace, gave a Veterans' Day interview about the program, obviously explaining its benefits for the Army and for the men involved. The newspaper headline, however, reflected some of the ambiguity of society about amputees when it called them "handicapped."³³¹ No further information about this program, or its developments, has been found, but the oft-cited cases of Generals Eric K. Shinseki (patient, April 1970-March 1971) and Frederick M. Franks Jr. (patient, May 1970-January 1972) are not unique.

Changing Patient Population

An all-volunteer force meant a higher percentage of the military was choosing a military career. They did not expect to give up families, and one byproduct of the Volunteer Army has been an increased number of dependents. Active duty personnel have dwindled as a percentage of eligible beneficiaries. In both the 1970s and 1990s reductions in military numbers added to this, as active duty personnel fell (as did active duty family members) but the number of retirees did not drop correspondingly. GME still required a diverse mix of patients and diseases, and thus the AMEDD had to perform procedures with no military utility, and it needed patients with those problems in order to meet civilian educational criteria. For instance, bariatric (stomach reducing or bypassing) surgery has no battlefield use and no use for active duty personnel who would fail to meet physical standards before surgery was indicated. The need is low enough that cases among retirees or Active Duty Family members could be sent to civilian hospitals, but the surgeries are state of the art and normal in civilian medicine, and it could be argued the Army should do them.³³² Similarly, there are periodically newspaper stories about Army plastic surgeons performing breast-enhancement surgery that is standard training for plastic surgeons. To train and retain plastic surgeons, the military has to perform these surgeries that have negligible relation to wartime missions.

CHAMPUS evolved into TRICARE in 1993 with modest changes for the AMEDD. An initial trouble was that TRICARE contracts trumped the DoD-VA sharing

³³¹ "Army Will Call Amputees Back to Active Duty: Regulation is 'Break' for Handicapped," Washington Times-Herald, 11 Nov 1951, p.13. I am grateful to Dr. Rebecca Hooper for this article.

³³² CPT Stephen Smith and COL John Major, "Operations for Morbid Obesity: Is there a place for them in military hospitals?," Military Medicine, (Feb. 1981), pp.95-97

agreements except in regions where the VA was part of the TRICARE group.³³³ This would be ironed out in later versions of the contracts. Even TRICARE For Life (established 2001) had only a modest impact on the patient population. Some over-65 patients had always been treated in military facilities (not just the exceptional cases such as Pershing or Eisenhower, but patients needed for GME) and even with TFL they could only use military facilities when there was space available. TFL does suggest a changing mentality about military healthcare, that it is an entitlement program rather than focused on conserving the fighting strength. With the Congress establishing TFL in 2001 and low casualties in the 1980s and 1990s, the AMEDD seems to have increasingly focused on TDA facilities and care instead of TOE units. The AMEDD considered TFL “a step in the right direction toward keeping faith with our most senior retirees,” a comment that reinforces military health care as an entitlement.³³⁴

Those few wounded meant the AMEDD could lavish care on the individuals that were coming home. All wounded could be celebrated as heroes. But the low numbers also meant the public could focus on individuals in a way that was not possible in any previous war. Another facet of that individual focus was a higher political profile for casualties. Many of the deployments of the 1980s and 1990s had only moderate public support (Lebanon in 1982-4, Grenada 1983, Somalia 1992, Haiti 1994-5, Bosnia 1996-2004, Kosovo 1999) and that meant a higher political profile for casualties. No overt political move was required for the AMEDD to know that casualties needed the best available care. There may also have been calculated institutional interest. As an institution, the Army knew that it relied on volunteers, not draftees, and that perceptions of poor care for wounded could hamper recruiting. This may have played a role in decisions to provide maximal treatment.

No data is available on psychiatric diagnosis rates, but it seems reasonable to presume that combat-related psychiatric problems were few given the dearth of combat in this period. (At some point the term “combat stress” became “combat/operational stress,” reflecting stressors during a deployment but not from combat.) Since PTSD was not a

³³³ GAO Report HEHS-00-52, “Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies,” May 2000.

³³⁴ MG Patrick Scully, “Army Modernizes in Face of Shortfall,” U.S. Medicine, January 2001.

diagnosis until 1980, and the VA was assigned care of what was initially called “Vietnam syndrome,” the military only gradually developed care for PTSD.

While the VA is not a main focus of this chapter, a word about it is in order. The VA seems to have been very sensitive to political pressure in arranging care for special categories of patients. Vietnam veterans drew special attention, especially PTSD patients. Women veterans, former POWs, Gulf War Syndrome, and Agent Orange sufferers all were rewarded with special coordinators or programs after effective lobbying.³³⁵

In a sense, the greatest change in the population was in how the Army thought about itself, a cultural change in the Army. Unlike the draftee era, when officers were volunteers and senior officers were Regular Army, career military, and junior enlisted were frequently draftees, all ranks were now volunteers, professionals, and people who identified themselves as Army. They would share a Soldiers’ Creed and all would be referred to as Soldier, with the initial letter capitalized to reinforce that all were alike.³³⁶ Wounded junior enlisted personnel wanted to stay in the Army, and would try to fight through rehabilitation to do so. (There may be unconscious reinforcement of another difference: it is possible to observe a wounded patient struggling to rehabilitate, while no such efforts are visible for a psychological casualty. It is possible to believe that one is trying and the other is not.) Greater common identification may have made the Army slower to discharge patients; VA benefits do not equal military pay, especially when disruption to a spouse’s earning potential is considered, and an AMEDD that believes its quality is outstanding can easily believe that VA medical care is not as good.

Rising Healthcare Costs

More elaborate medicine brought higher prices. Into the early 1990s there were concerns about World War III with the Warsaw Pact, and the military was somewhat insulated from cost-containment pressures. After big-war fears faded, the Army became increasingly cost-conscious. However, there were cost-containment moves in the 1970s and 80s. In 1974 the Chief of Staff approved contracting out of healthcare at 35 clinics, initially for selected functions (e.g. occupational and environmental health) but with the

³³⁵ For an overview of the VA, see Hamowy, cited in Chapter 5.

³³⁶ These changes were both after 2002, but were emblematic of long-term changes in the Army, as was the capitalization of Army Family.

potential to expand to small hospitals. This would have put TDA medical provision at those posts in the hands of civilian “hospitals, medical schools, private purveyors, and group practices.”³³⁷ After reviewing costs (and civilian healthcare could be costlier than military) and ongoing realignments of bases for two years, the program was tested in two. In 1976 this was expanded to contracting out Fox Army Hospital at Redstone Arsenal.³³⁸ For instance, some geographically isolated posts did not have Army healthcare but instead contractor-owned, contractor-operated clinics. When Fort Drum was reactivated for the 10th Mountain Division, no inpatient hospital was built; instead a clinic was built and local civilian hospitals were contracted to provide inpatient care, even for Active Duty personnel.³³⁹

In 1978 the VA, PHS, and DoD chartered a Federal Health Resources Sharing Committee to avoid overlapping of expensive capabilities. Some of the identified functions were CT scanners, cardiac catheterizations, and cancer treatment.³⁴⁰ This led in 1982 to the Congress passing Public Law 97-174³⁴¹ to encourage VA-DoD health sharing arrangements to reduce costs. This could range from laundry services to cardiac catheterization. Surgeon General Pixley stopped Eisenhower AMC’s proposal to develop cancer treatment programs because of local civilian capacity, and lauded the FHRSC “for increasing collaborative efforts. This is a concept I strongly support.”³⁴² In the mid-80s there were efforts to use the VA for CHAMPUS patients where it had capacity and was cheaper than the local civilian market.³⁴³ The purpose of the law was to reduce overlap and duplication, not to reduce services or change priorities.³⁴⁴

Even before the act, there was a 1981 MOU to transfer spinal cord injuries to the VA. The VA also regularly updated DoD about VA’s blind rehabilitation centers and head injury treatment capabilities, and the VA was responsible for any nursing home care

³³⁷ ARSG 1974. This may also have been a way to cope with projected personnel shortages.

³³⁸ ARSG 1976-80. It does not seem the AMEDD was particularly happy about this program. LTG Charles Pixley, “Army Medical Department,” Military Medicine (Sept 1979), pp.580-587. At the time of writing (February 2008) Fox Army Health Center is not entirely contracted out.

³³⁹ LTG Frank Ledford, “Army ‘Innovative’ in use of Funds,” U.S. Medicine January 1989.

³⁴⁰ ARSG 1976-80.

³⁴¹ Veterans’ Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, 4 May 1982.

³⁴² LTG Charles Pixley, “Army Medical Department,” Military Medicine (Sept 1980), pp.601-608.

³⁴³ LTG Bernhard Mitemeyer, “‘Volatile’ Year Sees Army Medical Gains,” U.S. Medicine 15 Jan 1985.

³⁴⁴ MOU Between VA and DOD, VA/DoD Health Care Resources Sharing Guidelines, 29 July 1983. By 2000 the collaboration had been formalized into the Military and Veterans Health Coordinating Board.

of active duty personnel who had reached maximum benefit of hospitalization.³⁴⁵ In 1992 the DoD sought VA expertise in amputations, with a MOU for the VA to be consulted on all amputations of active duty personnel, encouraging the DoD to purchase VA prostheses and related paraphernalia, and use VA rehabilitative services because this would both help the patient and contain costs.³⁴⁶ This was to apply for traumatic and therapeutic amputations alike, and did not necessarily lead to patient transfers to the VA.

This coordination for cost savings only increased in the 1990s. The number of DoD-VA agreements rose dramatically, although the dollars saved did not necessarily rise. There were also joint venture facilities. Mostly these were VA clinics beside (or in) military facilities, but there are joint medical centers, such as Tripler AMC.³⁴⁷ From 2,000 sharing agreements in 1989, the number rose to 7,500 in 1998 beside the five joint-venture facilities with three more in construction.³⁴⁸

There were also Military-Civilian Health Service Partnerships to try to contain costs. These allowed MTFs to bring in civilian providers for specific services, or even to use military personnel in civilian facilities if that would save CHAMPUS money.³⁴⁹

In the mid-80s there were questions about the AMEDD's cost and quality. (The bad press about foreign doctors and medical mistakes presumably led to perceptions of poor quality, and thus a need to reassure customers.) Surgeon General Mittermeyer brought eminent civilian medical managers to give their opinion and had to emphasize quality assurance and cost containment. QA programs were established to reassure personnel and beneficiaries they were receiving good care, and Congress demanded cost containment.³⁵⁰ Licensing and credentialing were early foci, as was rebuilding the percentage of board-certified physicians, and Surgeon General Becker established a task force reporting direct to him for quality issues. He also tried to reassure patients by

³⁴⁵ MOU, DoD and VA, Referral of Active Duty Patients to Veterans Administration Medical Facilities (Except for Locally Negotiated Agreements), 10 June 1986. The 1981 MOU has not been found, but is referenced in this MOU. Incidentally, this is the last use of the phrase "maximum benefit of hospitalization" seen in research for this project.

³⁴⁶ MOU, DoD and VA, Use of VA Prosthetic Equipment and Expertise by the Military in Support of Active Duty Patients, 26 Sept 1992.

³⁴⁷ See GAO Report HEHS-00-52, "Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies," May 2000, tables 2 and 3.

³⁴⁸ ARVA 1989-98.

³⁴⁹ DODI 6010.12, 22 Oct 1987. It is not known whether this was actually implemented.

³⁵⁰ LTG Bernhard Mittermeyer, "Quality Assurance: Major Army Focus," U.S. Medicine 15 Jan 1984 and "'Volatile' Year Sees Army Medical Gains," U.S. Medicine 15 Jan 1985.

getting more family practitioners and assigning families to particular physicians.³⁵¹ PRIMUS (Primary Health Care for the Uniformed Services) clinics were also established, with contract personnel in contract facilities on posts, treating beneficiaries rather than troops. Per visit these were cheaper than CHAMPUS network appointments, but might have created demand and thus not saved money.³⁵² With the first Base Realignment and Closure round in 1988, Letterman AMC was closed and one of the considerations in expanding Womack Army Hospital was that the expansion would recapture CHAMPUS patients from the network.³⁵³ Catchment-area management was also begun in 1990 to control costs.

With very few casualties in the 1990s, Surgeons General could focus on running the AMEDD as an efficient health-maintenance organization.³⁵⁴ Unsurprisingly, health promotion and preventive medicine became higher-profile activities in this period, partly because prevention/promotion is better for the patient, partly because new techniques were available, but partly because it promised to save money. Dependents and retirees were also absorbing a larger and larger percentage of time and money, because active duty personnel are younger and healthier, and they represent a smaller proportion of the beneficiary population. Perhaps the pithiest summary of the role of the AMEDD was when the Chief of Staff of the Army said that medical care for beneficiaries should not be cut due to deployments of AMEDD personnel.³⁵⁵ Surgeon General Blanck held that cutting corners “would be a violation of our core values and would break faith with our soldiers, past and present,” pointing to the AMEDD’s emotional tie to veterans, not just the GME interest.

Rounding out the point on customer satisfaction, it was, at times, also a way of reducing costs.³⁵⁶ Under late CHAMPUS contracts and the first TRICARE contracts,

³⁵¹ LTG Quinn Becker, “Medical Readiness Primary Army Focus,” U.S. Medicine, January 1986.

³⁵² LTG Quinn Becker, “Army’s Program Aims for Flexibility,” U.S. Medicine, January 1987; <http://www.cbo.gov/ftpdocs/84xx/doc8438/88doc06c.pdf>

³⁵³ LTG Frank Ledford, “Army Increases Combat Readiness,” U.S. Medicine, January 1990. The next point was that having tertiary care beds at Fort Bragg to handle casualties from early-deploying units, supporting their morale.

³⁵⁴ See LTG Alcide Lanoue’s articles in U.S. Medicine, 1993-96.

³⁵⁵ Presumably GEN Dennis Reimer, although not named. LTG Ronald R Blanck, “Army Approaches Being ‘The Best’,” U.S. Medicine, January 1997.

³⁵⁶ LTC. Deborah Kelly-Hoehn wrote an Army War College Strategy Research Project about “Perception of Quality of Health Care in the Military.” Carlisle Barracks, 2001.

dependents could opt for private care if they chose; they did not need a Non-Availability Statement first. Since it was generally cheaper for the military to “make” healthcare than to “buy” the same service from civilians, the military sought to “recapture” patients from the civilian sector. Active Duty patients could not choose to get civilian care, but the parallel for the AMEDD was treating wounded patients: the Active Duty population wanted wounded cared for in Army hospitals, and that generated customer satisfaction.

Customer care also became something of an end in itself. “Customer satisfaction, in particular is, and will continue to be, a priority. It is not only important to provide quality care, and we do, but also it must be *perceived* by our customers as high-quality and compassionate care.”³⁵⁷ (original emphasis) The AMEDD did more for the Army than medically protect troops and treat wounded; it was a quality-of-life element. “Needs of the service” included convincing patients they received good care; that reinforced recruiting and retention. Surgeon General Blanck followed this up with “report cards” comparing MTF quality, access, and satisfaction performance against civilian standards and published standards. He also cited Army success on JCAHO surveys, with the Army’s average inspection scores above civilian averages.

Planning for War and Supporting Deployments

In the late 70s, the Army was short of medical resources to support a potential WWII. Surgeons General had to tell Congress that there were not enough hospitals or personnel to sustain the heavy casualties expected. The situation would improve slightly with better recruiting in the 80s, but the Army lacked enough medical personnel for wartime. ASD(HA) John Moxley and Rep. Robin Beard worked to see what national resources could be brought to bear on the problem.³⁵⁸ Over the period 1978-82 reports were written showing the fairly obvious: VA and civilian hospitals could be a backstop behind the military. The starting point was showing the ignorance and lack of coordination. In 1978 “The Army’s Health Service Command ... could not clarify the authorities and

³⁵⁷ LTG Ronald Blanck, “AMEDD Responds to Change,” *U.S. Medicine*, January 1998.

³⁵⁸ See John Moxley III, “Early Perceptions of Military Medicine,” *Military Medicine*, (March 1980), pp.165-68.

procedures for dealing with VA.”³⁵⁹ A 1965 VA-DoD agreement was unearthed, but VA thought that it was

limited in scope and purpose and may no longer be valid or useful. ... In any event, by early 1966 joint development discussions were abandoned. In early 1969, an unsuccessful effort was made to reserve a block of VA beds for DOD use. Since that time, neither VA nor DOD had updated any list of capabilities or anticipated needs under this agreement. And no firm commitment was ever made on the exact size or nature of capabilities to be requested or provided.³⁶⁰

While Rep. Beard was using the GAO to highlight the problem, Sec. Moxley had his own reports. The Study of the Problems Associated with Reliance on Civilian Medical Manpower and non-DoD Facilities during Periods of National Emergency, Mobilization, and War³⁶¹ found that civilian hospitals could take war casualties, even after military reservists in the civilian healthcare system were mobilized. At some point in 1979 the ASD for Manpower, Reserve Affairs, and Logistics advised the service Secretaries and the Chairman of the Joint Chiefs of Staff that in a major war DoD was planning (at a minimum) to treat casualties that would RTD within 60 days and those that other sources could not handle.³⁶² “Wartime hospitalization requirements in excess of programmed capability will be acquired from non-DOD sources.” Finding those sources was the next priority, and Moxley used the reports as momentum towards the Civilian-Military Contingency Hospital System, CMCHS. This would regulate patients (both RTD and non-RTD alike) to civilian hospitals by the airplane load. Groups opposed to nuclear war opposed the CMCHS on the grounds that it was a disguised way to prepare for nuclear war.³⁶³ This line of argument seems tenuous, and was strenuously denied by the military, but in 1984 the CMCHS became the National Disaster Medical System, defusing opposition by diluting the military role.³⁶⁴ The military never had to address how to handle long-term patients, but likely there would not have been space for all of them in military hospitals, and potentially not in the VA either.

³⁵⁹ GAO Report HRD-78-54, “Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing,” 14 June 1978.

³⁶⁰ GAO Report HRD-80-76, “The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Health System,” 26 June 1980.

³⁶¹ 15 March 1979, Maximus Inc. for the Office of Planning and Policy Analysis, ASD(HA).

³⁶² GAO Report HRD-51-56, “DOD Needs Better Assessment of Military Hospitals’ Capabilities to Care for Wartime Casualties,” 19 May 1981.

³⁶³ “Sounding Board: The Civilian-Military Contingency Hospital System – Pro and Con,” New England Journal of Medicine, (25 March 1982), pp.738-743. It was ultimately codified into DoDD 5136.9, “Civilian-Military Contingency Hospital System,” 2 June 1980.

³⁶⁴ See DoDI 6010.17, National Disaster Medical System (NDMS), 28 December 1988.

The other option was use of the VA itself, as foreseen by the Federal Board of Hospitalization in 1940. A provision of Public Law 97-174 gave VA the specific role of caring for military patients during national emergency or war, something the VA thought was new, that the law “adds a fourth mission.”³⁶⁵ Soon there were thousands of beds theoretically available in the VA for military use.

Operation DESERT STORM would be the first test of the systems. The VA was alerted, but not civilian hospitals of the NDMS. Initial casualty projections for DESERT STORM were significant, and the military mobilized substantial numbers of reservists to cope. (Reservists were also mobilized to backfill military hospitals. Due to the low number of casualties, the reservists mainly cared for beneficiaries during the operation.) The PROFIS had not been well maintained, and had many problems. Adding to the problems for deploying units was TDA facilities keeping back some available personnel to “preserve continuity.”³⁶⁶ With the uncertainty over casualties, there were efforts to maximize RTD in theater; 51 Army Medical Specialist Corps officers were deployed (although only five were PTs and three OTs), and over 95% of psychiatric patients were RTD.³⁶⁷ In the VA, every medical center planned and trained to receive wounded patients. Within 72 hours the VA identified 18,000 beds as available, and ultimately planned to handle up to 25,000 patients.³⁶⁸ 22 hospitals were even prepared for chemical casualties if such had eventuated. Surgeon General Ledford clearly had few qualms about utilizing the VA for Army patients.

From 1992-2002 there were no military operations that had a reasonable likelihood of generating casualties beyond the capabilities of the military hospitals. There was certainly routine liaison between the DoD and VA. Current Army contingency planning has the VA and NDMS performing exactly the same functions should there be a declared state of emergency or declared war.³⁶⁹ Military hospitals are expected to handle

³⁶⁵ ARVA 1982. It was turned into Health Services Command Regulation 500-3, 7 August 1986.

³⁶⁶ GAO Report NSIAD-92-175, “Operation Desert Storm: Full Army Medical Capability Not Achieved,” August 1992.

³⁶⁷ LTG Frank Ledford Jr., “Army Overcomes Combat Challenge,” U.S. Medicine, January 1992; Ritchie Hardwick, AMSC 45th Anniversary.

³⁶⁸ ARVA 1990, 1991.

³⁶⁹ MEDCOM Regulation 500-5-1, “U.S. Army Medical Command Mobilization Planning System System Description,” 1 June 2000. The rhetorical claim “We are a nation at war” or “an Army at war” has been made by various public figures, and Pres. George W. Bush has declared states of emergency to invoke

patients that will RTD within 60 days, and any excess medical capacity will continue to treat TRICARE beneficiaries on a space-available basis.³⁷⁰ The VA and civilian hospitals will treat patients who will take longer than 60 days to RTD or are not expected to RTD. The military has transferred patients to the VA; in 2001 69 patients were transferred (the majority to VA Medical Centers in Minneapolis, Palo Alto, Tampa, and Richmond).³⁷¹ These numbers fit with the blind/spinal cord/head injury categories and training accidents. They also suggest an AMEDD that was accustomed to providing something akin to “maximum benefit of hospitalization” before transferring a patient.

various powers under various laws. Apparently the provisions of Public Law 97-174 have not been invoked.

³⁷⁰ MEDCOM Regulation 500-5-2, “U.S. Army Medical Command Mobilization Concept of Operations,” 1 November 1999. These points are repeated in MEDCOM Regulation 500-5-8, “U.S. Army Medical Command Wartime Plan,” 8 June 2000.

³⁷¹ Global Patient Movement Requirement Center spreadsheet, “Destination VA Hosp 2001 to Current Date,” 15 January 2008.

Abbreviations

AEF	American Expeditionary Forces
AHA	American Hospital Association
AMA	American Medical Association
AMC	Army Medical Center
AMEDD	Army Medical Department
AMSC	Army Medical Specialist Corps
AR	Army Regulation; Annual Report
ARSG	Annual Report of The Surgeon General
ARVA	Annual Report of the Veterans' Administration
ARVB	Annual Report of the Veterans' Bureau
ASD	Assistant Secretary of Defense
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASF	Army Service Forces
ASMRO	Armed Services Medical Regulating Office
ASTP	Army Specialized Training Program
BRAC	Base Realignment And Closure
BWRI	Bureau of War Risk Insurance
CCA	Career Compensation Act
CCC	Civilian Conservation Corps
CDD	Certificate of Disability for Discharge
CH	Convalescent Hospital
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMCHS	Civilian-Military Contingency Hospital System
CONUS	Continental U.S.
CSA	Chief of Staff of the Army
CT	Computerized Tomography
CY	Calendar Year
DAV	Disabled American Veterans
DNBI	Disease and Non-Battle Injury
DOD	Department of Defense
DODD	Department of Defense Directive
DODI	Department of Defense Instruction
EKG	electrocardiograph
E.O.	Executive Order
FBH	Federal Bureau of Hospitalization
FBVE	Federal Board for Vocational Education
FY	Fiscal Year
GH	General Hospital

GI	Government Issue
GME	Graduate Medical Education
GPO	Government Printing Office
JAG	Judge Advocate General
JAMA	Journal of the American Medical Association
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LOD	Line Of Duty
LS	Limited Service
MAOI	mono-amine oxidase inhibitor
MDWW	Medical Department in the World War
MEB	Medical Examining Board
MHI	U.S. Army Military History Institute (Carlisle Barracks)
MOU	Memorandum of Understanding
MTF	Military Treatment Facility
NDMS	National Disaster Medical System
NP	neuropsychiatric
OCONUS	Outside Continental U.S.
OMH	Office of Medical History
OT	Occupational Therapy
OTSG	Office of The Surgeon General, U.S. Army
PEB	Physical Evaluation Board
PHS	Public Health Service
PL	Public Law
POW	Prisoner of War
PT	Physical Therapy
PTSD	Post-Traumatic Stress Disorder
PVS	Post-Vietnam Syndrome
R&D	Research and Development
RG	Record Group
RH	Regional Hospital
RTD	Return To Duty
SecDef	Secretary of Defense
SGMC	Surgeon General's Morning Conference
SGO	Surgeon General's Office
SH	Station Hospital
TB	Tuberculosis
TB MED	Technical Bulletin, Medical

TDA	Table of Distribution and Allowances
TDRL	Temporary Disability Retirement Act
TFL	Tricare for Life
TOE	Table of Organization and Equipment
TSG	The Surgeon General
USAF	U.S. Air Force
USD(P&R)	Undersecretary of Defense for Personnel and Readiness
VA	Veterans' Administration, later Department of Veterans' Affairs
VB	Veterans' Bureau
VFW	Veterans of Foreign Wars
VJ	Victory over Japan
WIA	Wounded In Action
WWI	World War I
WWII	World War II
WWIII	World War III